S. HRG. 98-1151

HEALTH CARE COST CONTAINMENT STRATEGIES

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

EXAMINING HOW BEST TO CREATE AN ENVIRONMENT THAT WILL INSTILL THE COMPETITIVE MARKET FORCES IN THE HEALTH CARE DELIVERY SYSTEM AND TO ELIMINATE THE INEFFICIENCIES THAT PRESENTLY EXIST THERE

JUNE 21, 1984

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HEALTH CARE COST CONTAINMENT STRATEGIES

THURSDAY, JUNE 21, 1984

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:45 a.m., in room SD–430, Dirksen Senate Office Building, Senator Dan Quayle (acting chairman of the committee) presiding.

Present: Senators Quayle, Grassley, and Kennedy.

OPENING STATEMENT OF SENATOR QUAYLE

Senator QUAYLE. The committee will come to order.

This is the second of three hearings that we are going to have on health care. The first hearing that we had dealt with technology assessment. We had a number of witnesses that came forth and gave their ideas on how we could improve our legislation. I might report that we are still working with Senator Hatch and Senator Kennedy on our technology assessment bill so we can hopefully effect it in the nature of an amendment that may be offered on the floor later on this year. I am still hopeful that that legislation can come forward. The administration, Dr. Brandt, was very helpful in giving some constructive ideas on how we could progress better.

We will have a third set of hearings on July 10 that will explore defensive medicine and that will conclude a series of three hearings in the area of health care. These hearings today are going to explore the strategies on how we should be dealing with the issue of health care.

I don't think that there is any doubt about it, and there is certainly bipartisan support in the Senate and in the Congress, and there is certainly a lot of support around the country to do something about health care costs. I might add that the recent statistics, at least, show that costs have been reduced. Of course, inflation has been reduced, but there is still a growing concern, not only with the elderly that are most affected, particularly in medicare, and we will be hearing from Mr. Helms on proposals of what HHS will be doing, but there is also a new constituency, if I might call it such, that is being heard out around the country concerning health care costs. This is the businesses, and particularly small businesses, small business men and women, who are putting together health insurance proposals for employees. If you ask them, and I believe and I have said that the most talked about issue in corporate

boardroom America today when they get on the expense side of the ledger would be the increase in health insurance premiums.

When that dominates the discussion, whether it be in business or labor community, or whether it would be with the elderly, or here in the Halls of the Congress where we wrestle with the medicare problem almost on a biannual basis through the budget process and then the appropriation process, we have concluded with Social Security, that it is certainly a major issue, an issue that needs to have attention. I think there won't be any dispute that the issue is important and that the issue needs to have serious scrutiny about where do we go and how do we get from here to there.

There will obviously be, as in all cases, a disagreement on how to deal with that issue. I think today what I would hope, and I believe that the witnesses' testimony that I have read, will in fact direct themselves to the strategies and what should we be doing in this particular area and how can we best say what will be the follow on to the prospective payment reimbursement that we have under the medicare provisions in the Social Security Act that was passed last year.

So, we will be hearing from a number of very good witnesses and will be having some good questions. I know that the chairman of the committee, Senator Hatch, is intensely interested in the area of health care. He has been on the forefront of a number of issues, and I know that he will be having some written questions for our committee. As I indicated, we are working with him and with Senator Kennedy on technology assessment, and we will wait to see what does come out of these hearings to see whether there is any kind of a consensus that will begin to gel on strategies.

I have personally taken a very definite approach that I feel that we ought to look at somewhat of an incremental approach, that the facts really aren't all in, particularly on the prospective reimbursement of medicare. I think there are other things that we ought to do. Technology assessment is one. Consumer information is another. How can we get more information out to the consumer to help make these choices? I notice by today's press reports that the administration is interested in this as well. Another thing is how can we get more of the HMO's, the competitive plans, PPO's, and PPA's more involved in this system.

What I would like to do, and I know a number of witnesses will touch upon this, is, and I think this is really the question, at least from where I am coming from as a strategy on where we go, how best can we create an environment that will instill the competitive market forces in the health care delivery system. At the same time, how can we direct our concern and attention at the inefficiencies that presently exist there? I think that that really is our main challenge. How do we go about creating this environment and the best way to get those desired results that we all want to have.

I believe that there are basically three goals that each and every one of us share. That is, we all want to see quality medicine, we want to see access, and we want to see it delivered at a low cost. Those are three goals that nobody will dispute, but it seems that you can always have about two out of those three goals. You can have quality and access. That is no problem; you don't have to

worry about cost. Or you can have cost and access and forget about quality, or you can have quality and cost and forget about access. But it is very difficult, and that is where we come down on taking care of those basic three goals and those charges and to see how we are going to proceed forward.

So, with that, I will put the rest of my statement in the record and yield to Senator Kennedy who, obviously, has had a very long-time interest in this subject.

[The prepared statement of Senator Quayle follows:]

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Opening Statement by U.S Senator Dan Quayle (R-IN)

Before the Senate Labor
and Human Resources Committee

Hearing on
Cost Containment Strategies

June 21, 1984

This hearing is the second in a series of three hearings the Labor and Human Resources Committee is conducting on health care cost containment issues. The first hearing in the series was held on June 7, and focused on health care technology assessment. The final hearing, scheduled for July 10, will explore the cost implications of defensive medicine and medical malpractice. The hearing today will focus broadly on strategies to contain continued growth in this nation's health bill.

The hearing on June 7 provided important direction in the expanding area of health care technology. Testimony that day clearly indicated the need for more and better assessment of health care technology and for improvement in systems for disseminating information developed by assessments. There was a consensus that the private sector should assume an even more active role in promoting assessment. Furthermore, there was agreement that the private sector, in partnership with government, should encourage more coordination between the groups carrying out assessments and support the development of an entity, such as the one proposed by my bill, S. 2504, to act as a clearing-house for information on health care technologies.

More assessment, better coordination of assessment activities and improved dissemination of assessment information will not be a cure-all. However, by fostering the most appropriate use of health care technologies, these activities would help hold down health care costs and contribute to an even higher quality of care.

In order to provide for the establishment of a private-public sector consortium to further the appropriate use of health care technology, Senator Hatch and Senator Kennedy have joined with me to modify S. 2504. These modifications will be incorporated into an amendment that will be added to S. 2559, the Health Professions Training Assistance Amendments of 1984, which includes the reauthorization for

the National Center for Health Services Research, already involved in technology assessment for the Federal government. I appreciate the assistance of the Committee Chairman and the ranking minority member. I feel confident our amendment will complement and enhance current activities in technology assessment.

This initiative in the area of health care technology provides a useful example of the sort of action the Congress can and should take to foster the progress now being made in health care cost containment. Unquestionably, the high cost of health care to the Federal government, state governments and to the private sector is one of the most important issues we must face in the coming decade. However, a number of promising new strategies to resolve the problem of high health care costs are even now being implemented and devised. The prospective payment system for Medicare, for example, is having a profound effect on hospital utilization and cost. Early indications are that hospitals are reducing staff levels and taking other actions to streamline their operations. This means care will be less costly for all.

In addition, employers are helping to reduce costs by restructuring health benifit plans, and joining in business coalitions to become more aggressive players in the health delivery system and more prudent buyers of care. All of these strategies are changing the incentives in the health care system. They are making physicians, hospitals and

consumers more aware of the cost of care and how they spend each health care dollar.

Further reforms will be required, but I do not believe comprehensive change is necessary or appropriate at this point.

I believe that cost-control solutions should be incremental. We should pursue step-by-step approaches that complement existing strategies designed to change incentives for reducing expenditures rather than imposing caps on costs through system-wide Federal regulations. At a time when the health care system is responding to new incentives, we would be wrong to apply new sanctions. Significant new actions would interfere with the current moderation in health cost increases and perhaps even lead to the deterioration of our health care system.

The step-by-step reform I advocate would promote the reduction of health care costs through market-oriented policies by encouraging competition between hospitals and physicians on the delivery level and insurers on the financing level, while making consumers more conscious of the economic implications of their health care purchasing decisions.

The reasons for rising health care costs are as complex as our health care system itself, and any proposed solution

to the problem must account for a host of economic, social and political factors. I am convinced that the incremental approach is far better suited to the task of containing costs in our decentralized and pluralistic health care system than proposals to cap costs through the imposition of system-wide Federal regulations.

I have introduced a package of bills incorporating this incremental approach. The first of these initiatives to receive the attention of the Committee was S. 2504, the technology assessment bill. The other bills, S. 2501, S. 2502, and S. 2503 would provide for greater use of competitive medical plans and preferred provider arrangements, initiate cost-effective preventive health activities by requiring employers to give employees access to blood-pressure check-ups at least once a year, and commission a study by the Secretary of Health and Human Services (HHS) of the feasibility of providing consumer and payers information on health care costs and quality.

The reforms I have proposed are consistent with recent developments in the health care industry. They build on the principles of consumer choice and competition among alternative medical plans. And they would require minimum effort to be implemented.

Today's hearing will cover alternative paths to containing health care costs. I look forward to the discussion of contrasting philosophies and approaches.

I would like to thank the Chairman of the Committee, Senator Hatch, for giving me the opportunity to chair this important hearing. I know he is vitally interested in the subject as are the other members of the Committee. Also, I would like to thank the witnesses for taking time from their busy schedules to come today to appear before the Committee.

STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Senator KENNEDY. Thank you very much, Mr. Chairman. I want to express my appreciation to you for chairing these hearings and for your cooperation in working out a process by which we can hear from witnesses that reflect different viewpoints on the whole issue in question of health care in our society.

I think you have identified very well what the principal question is before us as a society in your opening statement where you talk about quality, access, and cost. There really is only one program that is before the Congress at the present time that I think is effective in dealing with those issues, and that is the program which I and Congressman Gephardt have offered and is cosponsored by many of our colleagues in the Congress.

We are facing once again a health care crisis. Our medicare system will be $1 trillion in debt by the year 2000. I will be interested to hear from the administration officials how they are going to deal with that and deal with it effectively, because the only thing that we have heard from the administration on this subject is higher taxes and fewer benefits.

I think the American people are entitled, as we have an election year, to have a full ventilation of this issue. They have a right to know what the administration proposes, because health care is a matter of enormous importance to the average American family. It is particularly important to our senior citizens who are facing, with what the Congress has submitted since this administration has been in office, and with the additional reductions reported by this administration, some $30 billion of reduction in benefits under medicare over the next 5 years.

So, Mr. Chairman, I look forward to these hearings. I am interested in competition, but we understand very well that we really don't have competition in the true sense in health care. Consumers don't make a choice. When they are sick they rely on the doctor to tell them whether they have to go into the hospital and whether they need certain drugs and whether they need certain treatments or they don't. It isn't a question of whether you buy a Chevy or a Ford or a Chrysler on which the consumers can make a judgment.

One of the real challenges will be how are we going to deal with this medicare deficit and excessive cost inflation in the future. We clearly have a dramatic increase in health care inflation. The elderly people, particularly, are faced with increasing costs, and an increasing percent of their fixed incomes, in most instances, that must be used to cover health care needs.

The question now is: are we going to take benefits back from needy people in our society or are we going to really develop a strategy that is going to reduce that excessive inflation in health care costs. My proposal and Congressman Gephardt's proposal says, let us build on what the Congress has accepted in terms of medicare prospective budgeting and say, if it is good enough for medicare, it is good enough for the whole health care system. We need not have a significant and dramatic reduction in needed services for people in our society.

So, I thank you for having this hearing. I would like to include my statement in the record as well, and I look forward not just to sharing this hearing with you but also in working with you to try to come up with some proposals to deal with the real needs of the people in our society.

Senator QUAYLE. Without objection, your statement will be included in the record.

[The prepared statement of Senator Kennedy follows:]

STATEMENT OF SENATOR EDWARD M. KENNEDY
ON
COMPETITION IN THE HEALTH CARE MARKETPLACE
JUNE 21, 1984

Our hearing today deals with the definition and solution of one of the most important problems facing American society: excessive inflation in health care costs. In the twenty years between 1960 and 1980, health care costs per capita have risen more than 1,000 percent, or four times as much as the consumer price index. The share of our gross national product going to pay for health care has doubled from 5.3% in 1960 to 10.5% in 1982. This year our country will spend one billion dollars each and every day of the year on health care.

Excessive health care cost inflation burdens every segment of our society, but our hearing today will focus on three groups that pay a particularly heavy penalty: American business and labor and the elderly.

We all know that our economy is still struggling to recover from the Reagan depression -- the worst depression since the second World War. We also know that American business and labor are facing the greatest international economic challenge in our Nation's history as they fight to compete in world markets. This year, our manufacturing trade deficit will be an estimated $80-100 billion and it is likely to be worse this year.

Excessive inflation in health care costs is a significant contributor to our society's economic problems. In 1982, the total health insurance tab paid by American business was $81.1 billion. The business share of payroll taxes to finance the Medicare program was $15.3 billion. The combination of employer-paid health insurance premiums and the business share of Medicare taxes was 96% of the total profits earned by all American corporations in 1982. American business will have to invest $270 billion per year for the next five years just to finance the increase in health insurance benefit costs in excess of general inflation and the Medicare cost shift already legislated. Virtually every labor negotiation in the last year has involved attempts by management to reduce health insurance benefits. Corporations are taking these actions because, even with favorable tax treatment, they find it increasingly difficult to finance ever-escalating health costs.

In sum, excessive inflation in health care costs robs American workers of needed wage increases, boosts consumers prices, threatens hard-won health insurance coverage, disadvantages American corporations in international competition, and drains capital resources that could be far better invested in improved productivity plant modernization, and product improvement.

As burdensome as excessive health care cost inflation is for American business and labor, the elderly are perhaps the most victimized members of our society. Excessive health care cost inflation burdens our senior citizens in two ways. First, as the group in our society in greatest need of high cost medical services, the elderly are uniquely vulnerable to excessive inflation in health care costs. In 1977 the average health costs the elderly had to pay out of their own pockets totalled

$698 per person. Today, those costs have risen to over $1,500. If health care cost inflation is not checked, the elderly will have to pay an average of almost $1,900 by 1983 and over $4,600 by the year 2000.

Figures on absolute dollar expenditures do not tell the whole story. A senior citizen spending the average $1,500 this year will have devoted 15% of his or her income just to purchase needed health care. Fifteen percent of income is the same proportion the elderly had to pay before medicare was enacted and it is more than one dollar in every seven of the elderly's limited income.

These figures on what the elderly must pay out of their own pockets for medical care assume the continuation of the medicare program in its present form. The sad fact is, however, that excessive health care cost inflation jeopardizes Medicare's very existence.

From the day it was signed into law 19 years ago, Medicare has stood as a solemn promise that the miracles of modern medicine will not be denied to our senior citizens and that their golden years will be free from the fear of financial ruin because of serious illness. According to the official estimates of the Medicare trustee, Medicare is likely to be bankrupt by 1991 under most likely economic assumptions. By 1995, the accumulated deficit will reach $155 billion. And by the year 2000, the deficit will exceed $1 trillion. If we were to try to eliminate this deficit by cutting Medicare's already limited benefits, we would have to cut medicare benefits by one third. If we were to try to eliminate the deficits by raising taxes, we would have to raise Medicare's payroll tax by about 50 percent.

What is the Reagan Administration's response to the crisis in health care costs confronting American business and labor and our senior citizens?

If the President has any plan to solve the Medicare crisis, he apparently plans to keep it a secret until after the election. But the Reagan record to date shows where the President's preferences lie: blame the Medicare beneficiary for the problem.

In the 3½ years it has been in office, the Reagan Administration has offered a harsh program of proposed and enacted Medicare benefit cuts that could take $1,000 from each senior citizen over the next five years and do nothing to resolve the Medicare financing crisis. The Reagan Administration's hand-picked Social Security Advisory Council has presented a proposal that would raise the age of Medicare eligibility to 67, impose higher copayments and premiums on Medicare beneficiaries, place new excise taxes on the American people, shift health car costs from Medicare to the private sector, and tax the health care benefits of workers participating in employment-based health insurance plans.

What has the Reagan Administration offered American business and labor? It has supported a Medicare-only prospective reimbursement system that could shift as much as $20 billion in health care costs to employers and employees over the next five years. It has proposed to impose $40 billion in new taxes on employment-based health insurance plans.

And finally, it has said to the business community that the brave new world of competitive markets in health care will somehow solve all their health cost problems. And if that patent medicine cure doesn't work, that is just too bad, because after all, the only responsibility of government is to hold down its own costs. Everybody else can look out for himself.

While this sort of nineteenth century social approach fits in perfectly with the Reagan Administration's approach to other social problems, I do not believe it is what the American people want, and it is certainly not the approach I support.

I believe there is a fairer and more effective way to deal with our national crisis over excessive health care cost inflation than taxing the health insurance benefits of American workers and denying our senior citizens Medicare benefits. That better way is a comprehensive national reform of the wasteful way we pay for health care. Congressman Richard Gephardt and I have proposed such a comprehensive reform: the Medicare Solvency and Health Care Financing Reform Act of 1984. Our plan will eliminate the Medicare deficit without reducing benefits or increasing taxes. It will save the private sector $70 billion over the next five years and reduce the Federal deficit by $30 billion.

Our plan is to establish a flexible and comprehensive approach to the health care cost problem. It allows each State to determine its own approach to health care cost control as long as that approach is fair and effective and meets Federal cost targets. Our plan combines regulation with competition. It will not choke off promising innovations or discourage private initiatives, but it will assure the cost control job gets done.

I look forward to the dialogue we will have today on the cost control problem and the merits of the Kennedy-Gephardt approach to that problem compared with the recommendations of the Reagan Administration and others.

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Senator QUAYLE. Before we proceed with the first witness we will receive for the record the prepared statements of Senator Hatch, the chairman of the committee, and Senator Thurmond, a member of the committee, both of whom were unable to be present today.

[The prepared statements of Senator Hatch and Senator Thurmond follow:]

PREPARED STATEMENT OF SENATOR HATCH

Today we continue the Senate Labor and Human Resources Committee's oversight hearings evaluating strategies for controlling the rising costs of health care in our country. Last year we compiled a two-day hearing record on how to reduce health care costs. Today's hearing reflects what has happened since then and allows us the opportunity to review the success of various containment models.

The American health services industry is in a state of dynamic evolution. In the past year a number of significant developments have occurred that will contribute to reducing total health costs:

Continued growth in membership and number of Health Maintenance Organizations (HMOs);

Increased numbers of Preferred Provider Organizations (PPOs);

AMA recommendation for a freeze on physicians' fees; and

Improved hospital cost controls as a result of Medicare implementation of a prospective payment system.

These changes indicate that health costs do respond to appropriate incentives, innovation, and free-market competition, with minimal federal regulation.

As is well-known, I am an advocate of decreased federal regulatory burden on the health care marketplace. I do not support proposals which require federally imposed caps on hospital revenues. For one thing, I do not think they will save money except to the extent they diminish quality and access. Rather, all of society needs to join a cost-containment strategy. We need to consume less unnecessary "health care." We need to advocate preventive methods of health care and healthy lifestyles. We need to foster an enterprising marketplace for health care providers and evaluate alternative health care delivery strategies. We need to become rational consumers of health care.

In general, 1983 total health cost expenditures consumed over 10 percent of our gross national product. These increasing costs represent an increasing burden on all Americans. These hearings will provide an opportunity to review what has happened, identify successful strategies, and consider proposals for making health care services more economical and more efficient. I look forward to the testimony of our witnesses.

PREPARED STATEMENT OF SENATOR THURMOND

Mr. Chairman: It is a pleasure to receive testimony from our distinguished guests this morning on the critical issue of health care cost containment. You are to be commended for holding this hearing, as it is essential to the recognition and correction of the problem of rapidly escalating health care costs which faces our Nation today.

I believe the health of our country's people is of utmost importance, and I am a firm believer in maintaining a high standard of one's health and well-being. We are faced, however, with a severe problem of rising costs for quality health care, making it ever more difficult for our citizens to receive adequate health care at affordable costs. In order to successfully control one of the major categories of Federal spending, in order to preserve our economic and national defense strength, and in order to preserve a high quality of life for the American people, we must come to grips with this difficult problem.

Accordingly, Mr. Chairman, I look forward to receiving the testimony from our distinguished guests. I am hopeful they will provide this committee with insightful views on the issue of health care cost containment and helpful comments on the several cost containment bills (S. 2501, S. 2502, S. 2503, and S. 2504) which are pending before the committee.

Senator QUAYLE. Mr. Helms, proceed at your pleasure.

STATEMENT OF ROBERT B. HELMS, Ph.D., ACTING ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. HELMS. Senator Quayle, Senator Kennedy, it is a pleasure to be here this morning.

When the Reagan administration came in in 1981, we sat down to decide basically which kind of approach we wanted to take to health policy, and the basic question that we asked ourselves was, how could we create an environment to make competition, the marketplace, work in health care? How could we make the Government a more prudent buyer and also create incentives for all the major players in the system—the insurance carriers, the Government, consumers, the hospitals, and the physicians—to be cost conscious in their decisions about health care spending.

We rejected the notion that a regulatory approach was the way to solve this problem. We believe that there are changes that we can make in the medicare program to complement the prospective payment system, and changes that we can make in Federal tax policy that would provide strong incentives for efficiency in the delivery of health care without intruding into patient-provider relationships or threatening the quality of care. In other words, to create this "environment" that you were speaking of earlier.

You are all aware of the magnitude and persistence of the health cost problem. The share of the Nation's gross national product going to health care has grown from about 7.9 percent in 1972 to 10.7 percent in 1983. The Federal investment in medicare and medicaid has grown so large it is becoming a serious burden on the Federal budget and the U.S. economy. Between 1970 and 1980, medicare spending has almost doubled as a percentage of gross national product. During fiscal year 1984, medicare will spend $44 billion for hospital care and $20 billion for outpatient care.

Similarly, health benefits have consumed an even larger share of private employee compensation: approximately $65.8 billion was spent on employer health insurance benefits in 1982. A few years ago, health insurance was looked upon as a minor and deductible cost of doing business. Today it has become a major financial undertaking of private enterprise, and many employers have chosen to self-insure and adopt internal controls on employee health spending rather than rely exclusively on outside organizations.

What concerns me is not simply that number of dollars being spent on health care, but the evidence that the Nation's health care system is not as efficient as it should be. For example, there is considerable evidence of wide variations in the costs of health care. In 1982, greater than two-fold differences in per capita cost and the use of hospital services existed among States. Per capita health care expenditures ranged from a low of $278 to a high of $620, and hospital admissions per 1,000 population ranged from 95 to just over 200 admissions. Similar variations were observed in small areas such as adjacent counties in New England where elective surgery rates varied by a factor of two or more. These statistics suggest that a large amount of the inefficiency in the health care system can be eliminated by applying appropriate incentives. We need not abandon our commitment to high quality health care in

the name of making the health care system more efficient, but we must make our health care system more efficient if we are to preserve and expand the quality and access gains of the last several decades.

Fortunately, there is cause for some encouragement in recent data on health expenditure trends. Age-adjusted hospital admission rates per capita and lengths of stay have been declining for some time. The medical care component of the consumer price index is now at levels substantially below those of 1981 and 1982, and the hospital component of the index is below the 10-percent increase level for the first time in several years.

In the private sector, employers have begun themselves to undertake the difficult task of reducing private spending inflation, with indications of success which my testimony covers later. And, the early returns of data on hospital performance under prospective payment indicate that the new system is operating as intended.

These encouraging signals are far too preliminary to conclude that the health care cost problem is being solved, but they do indicate that we are on the right track. We need to pursue our course of strengthening purchaser and provider incentives for efficiency in health care delivery and financing. This course offers the most promise of achieving cost containment goals without sacrificing free access to quality health services that Americans demand and expect to receive.

Despite significant recent improvements, costs and expenditures continue to rise for several reasons: Comprehensive first dollar insurance too often hides costs from the view of both the patient and provider. Costs also continue to rise because private and public third-party payers have failed to act as prudent buyers of health services on behalf of their enrollees. Too often, the practice has been to pay virtually whatever is billed by physicians and hospitals, passing the costs on in the form of higher premiums or taxes.

The end result is that the entire nation pays for the high cost of health care but often in indirect ways: in higher employer-paid insurance premiums that reduce the financial resources available for increased wages and new jobs; in higher prices for goods and services to cover cost of the elaborate health plans which are favored by our tax policy; and in higher taxes to support medicare and medicaid.

If we are ever going to get control of health care inflation, we must correct the backward incentives built into our financing and delivery system. Federal health policy is a good place to start, because Federal tax and health programs have done much to hide health care costs and remove incentives for efficiency.

We have made a major step toward correcting these backward incentives toward the implementation of prospective payment which changes medicare from retrospective cost reimbursement of hospitals to a system of prospectively determined payments.

HHS will continue to collect data to identify how prospective payments of hospitals is working, to design and implement improvements, and to extend the prospective payment concept into new areas of reimbursement. The Department's recommendation on methods of including capital reimbursement under the prospective payment system will be the subject of a report to Congress due

in the fall of this year. The Department is also developing recommendations on the feasibility of paying skilled nursing facilities by prospective payments and the feasibility and advisability of including inpatient physician services in the prospective payment system.

In another important change in the medicare financial system, in May 1984, HCFA published proposed regulations on medicare payment to health maintenance organizations and competitive medical plans. These regulations expand the definition of entities that may participate in medicare on a prepayment basis and authorize medicare reimbursement on a prospective, per capita basis for those organizations that have a risk contract. Greater participation in medicare by HMO's and other competitive plans will be encouraged when the regulations are implemented later this year.

The administration's legislative proposals build on the prospective payment legislation and HMO changes mandated under TEFRA. The Federal Government's role in controlling health care costs is to improve the efficiency of medicare, allow States the flexibility to implement cost containment programs, and remove the reverse tax incentives that encourage excessive health benefits.

We have made several proposals, including a freeze on physician fees in medicare, a voluntary voucher proposal, and a dollar limit on the tax-free contributions that employers can make toward employee health benefits.

The purpose of the proposed limit on tax-free private health insurance is to stimulate private plans to consider needed reforms in their own benefits and reimbursement rules. Since there is not, in our view, any single right way to improve the efficiency of a health benefits program, we would not require private plans to employ any particular cost containment technique. Instead, Government's proper role is to limit the tax law's distorting influence on private choices, leaving employment groups to develop cost containment programs to suit their own needs. In short, the proposed tax cap is not a punitive tax on health benefits, but rather an effort to make the tax law neutral in the choice between added wages and added health benefits.

I am encouraged about activities in the private sector to control health costs. The private sector has responded because of the magnitude of the cost problems it faces, as you indicated in your opening statement, Mr. Chairman, and the realization that neither the Congress nor the administration had any magic solution to the health cost problem. In other words, it was up to the private sector to go out and solve its own problem.

My written testimony gives several examples about patient cost sharing, restructuring health benefits and amounts that are being saved in a number of places through private utilization review, the growth of preferred provider organizations, the growth of HMO's, and some other examples of steps being taken by Blue Cross and Blue Shield and also the role of health promotion.

Mr. Chairman, from these examples and others I am sure you will hear about in later testimony today, I think there is reason to be encouraged about the future. Nevertheless, while these kinds of innovations being developed in the private sector are exemplary, they are not necessarily representative of private health care financing taken as a whole. Regrettably, there remains a great deal

of inefficiency in health care financing that continues to be supported by the current tax system. We need to install incentives that will make private cost containment commonplace. By doing so, we will ensure that public and private progress in reducing health spending inflation is mutually reinforcing and consistent.

Thank you. I will be glad to try to answer your questions.

[The prepared statement of Dr. Helms follows:]

TESTIMONY BY

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE
SENATE LABOR AND HUMAN RESOURCES COMMITTEE

JUNE 21, 1984

Mr. Chairman and members of the Committee: I am pleased to have this opportunity to participate in this discussion of health care cost containment strategies.

When the Reagan Administration came to HHS in 1981 we declared that a new approach to health policy was necessary to deal with the health cost problem. We developed strategies for containing health care costs that are designed to make every participant more cost conscious. From the consumer to the employer who pays the bill, from the insurance carriers to the government programs, each should become a more prudent buyer and user of health care, and each should bear some risk of unnecessary health spending.

The Administration rejects the notion that increased government regulation is the appropriate or most effective means for controlling health care costs. We believe that there are changes that can be made in the Medicare program -- to complement the prospective payment system -- and changes that can be made in Federal tax policy that will provide strong incentives for efficiency in the delivery of health care without intruding into patient-provider relationships or threatening the high quality of care.

DEFINING THE PROBLEM

You all are well aware of the magnitude and persistence of the health cost problem. The share of the nation's GNP going to health care has grown from about 7.9% in 1972 to 10.7% in 1983. The Federal investment in Medicare and Medicaid has grown so large that it is becoming a serious burden on the Federal

budget and the U.S. economy. Between 1970 and 1980, Medicare spending almost doubled as a percentage of gross national product. During fiscal year 1984, Medicare will spend $44 billion for hospital care and $20 billion for outpatient care.

Similarly, health benefits have consumed an ever larger share of private employee compensation -- approximately $65.8 billion was spent on employer health insurance benefits in 1982. A few years ago, health insurance was looked upon as a minor and deductible cost of doing business. Today it has become a major financial undertaking of private enterprise, and many employers have chosen to self insure and adopt internal controls on employee health spending rather than rely exclusively on outside organizations.

What concerns me is not simply the number of dollars being spent on health care, but the evidence that the nation's health care system is not as efficient as it should be. For example, there is considerable evidence of wide variations in the costs of health care. In 1982, greater than two-fold differences in per capita cost and use of hospital services existed among states -- health care expenditures per capita ranged from a low of $278 to a high of $620, and hospital admissions per 1000 population ranged from 95 to just over 200 admissions. Similar variations were observed in small areas such as adjacent counties in New England where elective surgical rates varied by a factor of two or more. These statistics suggest that a large amount of the inefficiency in the health care system can be improved

by applying appropriate incentives. We need not abandon our commitment to high quality health care in the name of making the health care system more efficient. But we must make our health care system more efficient if we are to preserve, and expand, the quality and access gains of the last several decades.

Fortunately, there is cause for some encouragement in recent data on health care expenditure trends. Age-adjusted hospital admission rates per capita and lengths of stay have been declining for some time. The medical care component of the consumer price index is now at levels substantially below those of 1981 and 1982, and the hospital component of the index is below the 10 percent increase level for the first time in several years. In the private sector, employers have begun themselves to undertake the difficult task of reducing private health spending inflation, with indications of success which I will enumerate later. And the early returns of data on hospital performance under prospective payment indicate that the new system is operating as intended.

These encouraging signals are far too preliminary to conclude that the health care cost problem is being solved. But they do indicate that we are on the right track. We need to pursue our course of strengthening purchaser and provider incentives for efficiency in health care delivery and financing. This course offers the most promise of achieving cost containment goals without sacrificing free access to quality health services that Americans demand and expect to receive.

THE NEED TO CHANGE INCENTIVES

Despite significant recent improvements, costs and expenditures continue to rise for several reasons. Comprehensive, first dollar insurance too often hides costs from the view of both the patient and provider. Costs also continue to rise because private and public third-party payers have failed to act as prudent buyers of health services on behalf of their enrollees. Too often, the practice has been to pay virtually whatever is billed by physicians and hospitals, passing the costs on in the form of higher premiums or taxes.

We all recognize, of course, that the primary purpose of insurance is to spread the costs of illness so that concerns about the cost of care do not dominate clinical decisions. Yet it is possible to go too far, and the Administration believes that the public and private health care financing system has gone too far in hiding the cost of health care. Concealing costs to the extent we have has seriously exacerbated the health spending problem.

The end result is that the entire nation pays for the high cost of health care but often in indirect ways -- in higher employer-paid insurance premiums that reduce the financial resources available for increased wages and new jobs; in higher prices for goods and services to cover cost of the elaborate health plans which are favored by our tax policy; and in higher taxes to support Medicare and Medicaid.

If we are ever to get control of health care inflation, we must correct the "backward" incentives built into our financing and delivery system. Federal health policy is a good place to start, because Federal tax and health programs have done much to hide health care costs and remove incentives for efficiency.

We have made a major step towards correcting these backward incentives through the implementation of prospective payment, which changes Medicare from retrospective cost reimbursement of hospitals to a system of prospectively-determined payments.

The prospective payment system is already having a positive effect on the hospital industry. Most hospitals -- large and small -- are taking a serious and business-like look at their case mix profiles, analyzing practice patterns and costs by DRG and implementing patient management protocols. Hospitals are actively engaging in strategic planning, undergoing internal assessments and evaluating their mission, scope and relationships to the broader health care delivery system within the community. The DRG system has thus created an impetus for applying sophisticated business and management practices.

HHS will continue to collect data to identify how prospective payment of hospitals is working, to design and implement improvements, and to extend the prospective payment concept into new areas of reimbursement. The Department's recommendation on the method for including capital reimbursement under the prospective payment system will be the subject of a report to Congress due in Fall 1984. The Department is also developing recommendations

on the feasibility of paying skilled nursing facilities by prospective payment and the feasibility and advisability of including inpatient physician services in the prospective payment system.

In another important change in the Medicare financial system, in May 1984 HCFA published proposed regulations on Medicare payment to Health Maintenance Organizations and Competitive Medical Plans. These regulations expand the definition of entities that may participate in Medicare on a prepayment basis and authorize Medicare reimbursement on a prospective, per capita basis for those organizations that have a risk contract. Greater participation in Medicare by HMOs and other competitive plans will be encouraged when the regulations are implemented later this year.

LEGISLATIVE PROPOSALS

The Administration's legislative proposals build on the prospective payment legislation and HMO changes mandated under TEFRA. The Federal government's roles in controlling health care costs are to improve the efficiency of Medicare, allow states the flexibility to implement cost containment programs and remove the perverse tax incentives that encourage excessive health benefits. Among the proposals included in the Administration's package of reforms are:

- a one-year freeze on the fees that Medicare pays physicians, which will slow the rise in Medicare spending while HHS studies longer term reforms in physician reimbursement,

- a proposal to provide Medicare beneficiaries an opportunity to utilize the dollar value of their benefits by selecting a private health care plan more suitable to their specific needs,
- a proposal to index the Medicare Part B deductible so that inflation does not steadily erode the deductible's value as a deterrent to unnecessary utilization, and
- a dollar limit on the tax-free contributions that employers can make toward employee health benefits.

The purpose of the proposed limit on tax-free private health insurance is to stimulate private plans to consider needed reforms in their own benefits and reimbursement rules. Since there is not, in our view, a single "right way" to improve the efficiency of a health benefits program, we would not require private plans to employ any particular cost containment technique. Instead, government's proper role is to limit the tax law's distorting influence on private choices, leaving employment groups to develop cost containment programs that suit their own needs. In short, the proposed "tax cap" is not a punitive tax on health benefits but rather an effort to make the tax law neutral in the choice between added wages and added health benefits.

DEVELOPMENTS IN THE PRIVATE SECTOR

Before reviewing what the various components of the health market are doing to control health costs, let me review briefly some forces that have led to these private sector efforts.

The most obvious reason that people in the private sector have begun to pay more attention to health care costs was their realization that they could not afford to have health care costs continue to increase at 1970s rates without a devastating impact on government and corporations. This realization that something must be done has been a gradual process over the last five years and has been more intense in some states and sectors of the business community than in others.

Another factor that helped to change private sector attitudes was the realization in the late 1970s that Congress was not going to pass either national health insurance or a stringent regulatory system to control hospital rates. In 1981 Congress gave a strong signal to the states to control their own costs by giving them more flexibility to administer their Medicaid programs and various public health grant programs. The prudent purchaser principle embodied in the Medicare prospective payment

system established in the Social Security Amendments in 1983 gave a further indication that Congress supports an incentives-based cost management strategy rather than a regulatory approach.

Recent Congressional actions and the Administration's continued emphasis on health incentives reform transmit a clear message to the private sector -- take a more active and constructive role in designing solutions to the health care cost problems.

The diversity of private sector cost containment strategies is to be applauded and encouraged. The private sector is assuming a critical role in fostering market incentives that will promote cost containment and efficiency in the health care system. The following are examples of private sector cost management activities that are becoming increasingly evident throughout the country.

- First, surveys indicate an increase in patient cost-sharing in employer-sponsored health plans. According to the Hay-Huggins Survey of Non-Cash Compensation, about one-third of a broad sample of private firms had recently increased their health insurance deductibles. Another third were considering an increase. These figures are up considerably over the 1982 Survey results. The Rand Health Insurance Experiment, which is financed by my office, shows that cost-sharing can help control the costs of health care without significant adverse health effects.

- For the individual firm, the impact of cost-sharing can be significant. For example, U.S. Steel dramatically reduced its hospitalization rate for 18,000 salaried employees by adding a $304 deductible on hospital care. Since 1982, when the deductible was introduced, hospital admissions have decline by 20 percent. Similarly, a $50 deductible on outpatient emergency visits reduced those visits by one-third.
- Restructuring health benefits is another major area of private sector cost management activity. Some benefits packages now encourage second-surgical opinions by waiving the usual cost sharing. The Cornell Medical Center-New York Hospital study found that its mandatory second opinion program saved $2.63 in benefit costs for every dollar expended. CIGNA's second opinion program saved $2 million over a five year period, yielding an annual saving of $16 in surgical costs avoided for every dollar spent on consultations.
- There has been an increase in private utilization review programs and practice pattern monitoring to identify aberrant utilization and pricing patterns. The Iowa Foundation for Medical Care is the largest organization engaged in such activity. Utilization review in Iowa was partially responsible for an unprecedented reduction in private health insurance rates.

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- One of the Iowa Foundation's major clients is John Deere and Company. In less than five years, Deere's inpatient hospital days per 1000 insured declined by 31.2%, yielding a ten-to-one return on its financial investment in utilization review. Similarly, length of stay for San Diego firms participating in a hospital utilization review program is 42 percent lower than for firms not participating in the business coalition-sponsored program.
- Private cost containment efforts have also included the use of "preferred provider organizations" (PPOs). There are many different types of PPOs, usually the consumer retains a free choice of physician or hospital, although the PPO's sponsor (often an employer) attempts to steer the consumer to lower cost providers who have signed participation contracts with the PPO. The employer steers the consumer by reducing his cost-sharing if he goes to a "preferred" provider. Unlike HMOs, PPOs operate a fee-for-service basis. PPOs seem to achieve cost savings by contracting with providers at fixed rates of payment (often at levels below customary charges) and instituting utilization review programs such as pre-admission certification and discharge planning. Interest in developing PPOs is being expressed by physicians, hospitals, insurers, employers and business coalitions.

As you know, HMOs vary in their organizational structure, but what they have in common is a greater integration of health care financing and delivery than the traditional fee-for-service indemnity plans. Recent findings from the Rand study confirm that HMOs significantly reduce the costs of delivering medical care. The calculated expenditure rate was about 25 percent less in the HMO than for the fee-for-service group receiving free care. Further, hospitalization rates for HMO enrollees were 40 percent below the feefor-service group. These findings can not be attributed to a healthier HMO population.

The 1983 National HMO Census reported that HMO enrollment from June 1982 to June 1983 increased by 15.3 percent. There are 13.6 million members in 290 plans nationwide.

o More than a dozen Blue Cross and Blue Shield plans now have incentive programs to encourage early maternity discharges. Another two dozen are developing programs or conducting exploratory research to enable more new mothers to return home to their families soon after childbirth. Nationally, the cost saving potential of these programs is significant. If the average hospital stay for a normal delivery were reduced by only one-half day, savings could be between $40 and $50 million.

- o On June 13, 1984, the Blue Cross and Blue Shield Association announced guidelines designed to limit diagnostic CAT-scans, X-rays, ultrasound, thermography and other techniques that produce images of internal organs. They expect these guidelines to produced millions of dollars of savings annually.
- o Health promotion is another area of growing interest among employers. The Washington Business Group on Health reports that the majority of its 200 member firms currently offer some form of health promotion or employee education program.

CONCLUSION

As you can see Mr. Chairman, there is reason to be encouraged about the future. Nevertheless, while these activities are exemplary of the kinds of innovations being developed in the private sector, they are not necessarily representative of private health care financing taken as a whole. Regrettably, there remains a great deal of inefficiency in health care financing that continues to be supported by the current tax system. We need to install incentives that will make private cost containment commonplace. By doing so, we can insure that public and private progress in reducing health spending inflation is mutually reinforcing and consistent.

Now is not the time to rest, nor is it time to change direction. I believe these private sector efforts coupled with the recently enacted Medicare prospective payment system and earlier improvements in Medicaid represent a good start in slowing health care inflation. I wish to emphasize my belief that private decisions, motivated by the appropriate incentives, offer the greatest potential for bringing the health spending problem under control. This is why I have emphasized private sector cost containment activities in my remarks. I hope Congress and the Administration can build on the foundation that has been laid by reaching agreement on a package of reforms that stimulate still more purchaser and provider efforts at cost containment.

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Senator QUAYLE. Thank you.

Mr. Helms, on page 2, you talk about the inefficiency or the lack of efficiency in the Nation's health care system. Then you go on and talk about 1982 greater than twofold differences in per capita cost in the use of hospitals existed among States. We can probably find even within the State that there is a lot of discrepancy that exists.

What do you think is the single most motivating factor for that discrepancy to exist, whether it is interstate or intrastate, because it certainly does?

Mr. HELMS. As I am sure you know, there has been some rather careful research. It is an active field of research now, both in the Department and also by a number of different researchers. You can come up with some logical explanations of why health care expenditures vary—the age distributions of States differ, there is more sickness in certain areas—but these obvious kinds of explanations don't come anywhere close to explaining the variations.

The bottom line, I think, of this line of research, the best explanatory factor, is the difference in the style of care of certain physicians. This gets back to the incentives. People and physicians practice in a usual, customary way. They have been trained in a certain way. They have lived under a system for several years where they have not had the incentive to worry about the cost of care, neither the patient nor the physician. This is called the third-party payment problem. You know the first and the second party both have an incentive to make sure they use more and more medical resources as long as the third guy is paying for it.

So, I think the best explanation for this large variation is the difference in the style of care. That is what leads me to believe that there is room for a good deal of improvement in the efficiency

simply by creating this environment you spoke about, to get people to practice medicine in a more cost effective way and to get the patient and the physician to come in there and say, we have an interest in quality, but we also have to worry about the cost and let's see if we can do this in a very cost effective way so that you get good quality care but we don't run up the bill.

Senator QUAYLE. In creating this environment, and trying to get more efficiency into that, in your answer you indicated that we need to get the first and second part of the system involved rather than just the third party payer who always picks up the tab. If, in fact, we are going to get the first and second, particularly the first, the consumer or patient, more involved, isn't that person going to have to have some more access and more knowledge of the information of what the costs are going to be, what the quality is going to be, where they might go to get a better deal in health care, whether it be a business or whether it be an individual seeking that?

Along those lines, we introduced legislation to at least take a look at some of the States that have some information activities, Minnesota, Utah, and Iowa. We have some rather active groups out there that are trying to get more information out to the consumer. We have asked to look into this and to report back on how we might be able to achieve this.

I wonder if you have any ideas on how we might be more active in getting this information out to individuals, because there is, I think, somewhat of a lack of understanding of where to go. Is there a way that you can really sort of shop around, asking the right questions and getting the right information? People, by and large, sort of look at the bottom line, maybe on the health insurance premiums and sign up, but beyond that, there is really a startling lack of knowledge on the subject. I wonder what we can do to get more information out there?

Mr. HELMS. First, Senator Quayle, I am reminded that several years ago, two economist friends of mine, Paul Ginsburg and Ted Frech, did an analysis of the incentives and the production of useful information in the health care system. They pointed out that we have had a system that basically did not reward one for shopping around. Consequently, the incentives were not there with basically our first-dollar coverage and cost-based reimbursement—the third party payment problem.

So, we did not reward people for seeking out more cost effective providers. Therefore, over the years, we did not develop these institutions which could produce this comparative information. There wasn't a consumer demand for it, so it didn't exist.

There are examples of other places in industry and in the economy where consumers do have to deal with technical information and difficult decisions, and institutions and publications, and so forth, have come forward to produce it.

Now, the Government has a role in this, I think. We have recently asked for comments on some proposals to allow publication of more information which we will be collecting through the PRO system. As you know, there are great concerns on the parts of providers, particularly those who deal with the more difficult cases. As you know, some physicians have more patients that die, because

they treat more serious patients. They are good physicians. Serious cases are referred to them because they are good.

So, I think you do have to be careful in how you interpret raw outcome data. I do know that a lot of physicians have concerns about this. We have asked for comments on disclosing more of this information. We do support the principle and hope that we can figure out a way to do this in a responsible way.

Senator QUAYLE. Let me just shift your attention to another area, and that is the all-payer State regulation systems. I wonder if you might give us a response on how useful or beneficial you think that they have been and how well do you think that the current medicare waivers, which allow for such systems, are working as mechanisms to contain costs and make the providers more efficient?

Mr. HELMS. Well, as you know, we have been opposed to all-payer rate systems. The logical argument that we have used against this is that we think that we have a responsibility to be a prudent purchaser of health care for the public programs, medicare and medicaid. We try to set up a system to be a prudent purchaser.

However, the all-payer approach really takes the other third party payers off the hook. It sets the Government up to maintain or to set the rates for reimbursement and it takes the pressure off other payers to compete on the basis of cost containment. Some third party payers might prefer an all-payer system, but we are opposed to this approach. We think that it is far better by us to set the example by being a prudent purchaser and to let these other payers figure out the best way to reduce their own costs. That is what is going to promote more competition in the marketplace.

Senator QUAYLE. How about the waiver, the present waiver under the medicare for the State all-payers. Is that working, in your opinion?

Mr. HELMS. We have been reluctant to prohibit experimentation by States with all-payer rate controls, so we do have a system of granting these waivers. I think the evidence is less than convincing that they are going to be successful. There is some evidence that these State rate setting programs have not been all that effective. They happen to be located primarily in some of the highest cost States, but the evidence is not that good that they are all that successful, so far.

We recently have sent a letter to the State of New Jersey saying that we believe that their system is going to cost the medicare trust fund more than would the national prospective payment system. We have asked them to come in with another waiver request to see if they can get their costs down.

Senator QUAYLE. I have one final question, and then I will yield to Senator Kennedy.

Some will make the argument, as I have had it made to me both publicly and privately, that the prospective payment is a good idea, but there is this cost shifting that in fact is going on. You know what I mean by cost shifting—shifting it over to the private insurers. Is that really happening and, if so, what are we going to do about it? If not, would you amplify on why it is not, because this issue comes up time and time again.

Mr. HELMS. It has always seemed strange to me that these other payers have to allow costs to be shifted to them. I think it is important to keep the competitive pressure on the other payers. Let them figure out ways to get their own payments under control rather than just continue with the old system of third-party reimbursement under which, if they didn't question any of the payments, they might be victims of cost shifting.

But we think we pay a reasonable amount for the care for medicare and medicaid. You know, hospitals do have problems with bad debts. Medicare pays its share of those bad debts which are associated with the medicare patients, but we don't think we have the authority to create a new entitlement program for paying for the bad debts of nonmedicare recipients or people not covered under medicaid.

It is a problem, and we are studying some ways to see what we can do about it. I think the Secretary has some authority to study this now, but we think it is very important to keep that competitive pressure on the system.

Senator QUAYLE. But you think that is a problem and in fact there is some cost shifting and we are going to have to do something about that. Is that what you are saying?

Mr. HELMS. Well, I think people's perceptions of cost shifting differ. It is all——

Senator QUAYLE. You don't have any data then.

Mr. HELMS. No; we have looked at the data that other people have produced about their measurements of cost shifting. We think a lot of what is being said is that we are not paying for things which we have no authority to pay for. For example, these is the bad-debt problem. They say we don't pay for telephones and things like that in hospitals, which people do get bills for, and unsponsored research, those kinds of items.

Senator QUAYLE. Senator Kennedy.

Senator KENNEDY. Thank you very much, Mr. Chairman.

Mr. Helms, I am sure you are aware of the medicare actuaries' estimates that achieving trust fund solvency over the period of the future would require cutting either benefits by one-third or increasing payroll taxes by 50 percent. Which does the administration favor?

Mr. HELMS. We haven't taken a position on those.

Senator KENNEDY. Why haven't you? You have been in office 3½ years. It has been 9 months since the Bowen Commission recommendations have been public. Don't you think that we are entitled to know where the administration is coming out?

Mr. HELMS. Let me say something about the medicare trust fund problem. I do think it is certainly in trouble. My own impression is that it is in more trouble in the next century because of the basic demographics than it is in the short run. The projections are that it will go into insolvency in 1991 under the mideconomic assumptions.

However, I am somewhat optimistic. There have been some very pessimistic assumptions about what is going to happen to prices in the medical-care sector. As I said in my testimony, prices have really come down quite a bit. If all this activity that is going to be

the subject of later testimony continues to go on, I think those prices may perform better relative to the rate of inflation.

We are studying the Bowen Commission suggestions. I think we are going to have to face up to some set of proposals and they are going to be difficult choices.

Senator KENNEDY. When are we going to get those, after the election or before?

Mr. HELMS. They are very complex problems, and we will be looking at them, but I can say——

Senator KENNEDY. What is the answer to the question? Is it after the election or before?

Mr. HELMS. I think it will be after the election, sir.

Senator KENNEDY. Well, I think that is a terrible deception of millions of elderly people. With all due respect to your comments on the projections for the most recent report of your own actuaries estimate that the long-term deficit in the trust fund is higher than the trillion-dollar deficit that Congressman Gephardt and I noted when we prepared this legislation last year.

The figures you used today on the decline in inflation are really based upon the first quarter of this year. Last year, hospital-care costs went up 2½ times the rate of general inflation. I would not be very sanguine about how health-care costs are coming down based on one quarter of data.

Whether the long-term deficit is going to be $1 trillion, or $1.3 trillion, or $800 billion there is no question that we are talking about a very, very significant problem. If we follow what you are suggesting and don't do anything to bring this inflation down, we are going to have to see a significant reduction in benefits. That has clearly been the administration's approach to date, $30 billion in reduced benefits for elderly people over the period of the next 5 years.

I think it is dreadful that this administration can come up here to this hearing after 3½ years in office, after the recommendations of this administration's own panel to consider medicare alternatives have been public for 9 months, and refuse to tell us what is going to be the path of this administration until after the election.

We debate this issue over on the floor when we are faced with reductions in benefits. There is the conference now between the House and the Senate. I don't know whether it concluded last night, but the conferees were considering severe reductions in benefits passed by the Senate.

I just think, quite sincerely, that the American people, particularly the elderly people, are entitled to know where you are going to come out before this election. They deserve something better than the generalizations that you are going to study the problem and make some recommendations afterwards.

Let me ask you this, because we want to move on, if prospective budgeting is part of the administration's approach in dealing with the medicare crisis, why, if it is good enough for medicare, is it not good enough for the rest of the system?

Mr. HELMS. Well, as I said before, I think our responsibility is to be a prudent purchaser for our program. We do not want to apply that mandatory——

Senator KENNEDY. Well, is it good for medicare? Is it satisfactory?

Mr. HELMS. We think it is. As a matter of fact, we think the rest of the system is going to get substantial advantages from having prospective payment. It is really causing a revolution in the hospital sector. There is a change in behavior out there. There is a lot more effort being put out by the hospital industry into trying to figure out how to provide quality care in a more cost-effective way. The other payers are going to be advantaged by that.

Those rates are publicly available. Some insurance carriers, I think, are looking at that as a possibility.

Senator KENNEDY. Well, what is the leap in logic that says applying prospective payment to the rest of the system is bad. Our proposal would apply it to the rest of the system while permitting competitions between HMO's and the fee-for-service sector, competition between the various health-delivery systems, and competition between the hospitals. As I said, if prospective payment with competition is good enough for medicare, why not do it for the rest of the system?

Mr. HELMS. I think the major difference is that the way you are talking about doing it is mandatory.

Senator KENNEDY. Well, do you mandate it under the DRG?

Mr. HELMS. We do for medicare payments.

Senator KENNEDY. OK, then, you are mandating it for the medicare payments. Is that a heavy hand of Federal regulatory control?

Mr. HELMS. No, sir.

Senator KENNEDY. It isn't?

Mr. HELMS. I know we published several pounds of regulations to get prospective payment into effect. That is because they had a lot of complicated rules about how we should do it, but I think it is a world of difference in what it attempted to do and a pure regulatory approach.

Senator KENNEDY. Explain that to me, why putting the regulation in effect in terms of the prospective budgeting and reimbursement is nonregulation for DRG's and under medicare and why it is regulation under an all-payers system. I find that——

Mr. HELMS. It sets the rates that we are going to pay, and it gives the hospitals incentive to come in under that and keep the difference if they can. If they run over, then they pay the cost.

If we mandate that to all the other payers, the Government would be in the position of setting the rates across the board. We think there is something to be gained from having the other payers come up with their own system to control cost. If they want to use the DRG rates they can, or they can modify them.

I think the one thing that gets lost in this debate is the fact that the providers, and the physicians, and the hospitals have a stake in not letting the Government just mandate the prices across the board, but, rather, having these different payers compete on the basis of cost. Providers have some protection when you have competition going on from the different third-party payers.

Senator KENNEDY. I notice that the President, when he was talking to the National Alliance of Senior Citizens he said, and I quote:

There are those who claim that we cut Social Security and Medicare benefits, and I have to tell you, whenever I hear that, it sort of touches my temperature control. Nothing could be further from the truth.

Does he know that his administration has recommended $30 billion in medicare cuts? What is his temperature today?

Mr. HELMS. I don't——

Senator KENNEDY. That is all right; you don't have to answer that.

Thank you, Mr. Chairman.

Senator QUAYLE. Thank you, Senator.

Thank you, Mr. Helms. We appreciate your being here today.

Our next witness is Congressman Richard Gephardt. He has introduced, along with Senator Kennedy, the Medicare Solvency and Health Care Reform Act. He has a great interest in this legislation and a longstanding interest in the health care field. We appreciate his being with us today and welcome him to the committee.

Senator Kennedy.

Senator KENNEDY. Thank you, Mr. Chairman.

Mr. Chairman, I want to share in welcoming Congressman Gephardt to the committee today. He has worked long, and hard, and thoughtfully on this legislation, and we are delighted he can be with us today to give us the benefit of his views and his findings. I look forward to hearing his comments for this committee. I appreciate very much your presence here.

Senator QUAYLE. Having served with Congressman Gephardt for 4 years, in fact, elected the same year together, in 1976, we are somewhat neighbors out there in McLean. We live a little further out than you do. I used to get rides in to the House periodically. I miss those.

Mr. GEPHARDT. You didn't pay for the gas. That's why. [Laughter.]

Senator KENNEDY. Is that an all-payers system? [Laughter.]

Senator QUAYLE. No; it is a pay as you go. It is still cheap. I was trying to get cheapness, but it was very efficient for me to do that. [Laughter.]

Senator KENNEDY. Good quality, too, I am sure.

Mr. GEPHARDT. It has been a great pleasure to be here today. I think we have hit about everything I was going to say. [Laughter.]

Senator QUAYLE. Be that as it may, former colleague, go ahead and proceed at your pleasure.

STATEMENT OF HON. RICHARD GEPHARDT, A U.S. REPRESENTATIVE FROM THE STATE OF MISSOURI

Mr. GEPHARDT. I thank you for allowing me to be here today. It is an honor to appear and, obviously, an honor to be with Senator Kennedy. It has been a great pleasure to work with him in developing this legislation.

Let me start by giving a little history of my involvement in health care in the Congress starting when President Carter was trying to contain health care costs. I was a leader in the House effort to stop the Carter cost containment bill. The effort at the time was a voluntary effort in the private sector among providers to try to contain health care costs.

There was a belief that the cost containment proposal was not the best. There was a belief that the amendments that had been made in the committee had gutted it. There was also a belief that the private sector, acting voluntarily, could effect change.

I think it is clear now that in the 5 years since that effort was defeated, the voluntary effort has not worked. It was that realization on my part and my great concern, almost urgency about the problem that leads me to propose with Senator Kennedy a very specific and definitive plan for how to approach and deal with the overwhelming problem.

While we are talking about what costs have done in the last 5 years, I think it is important to put it in human terms and to put it in terms of what is happening with our medicare and medicaid funds. Recently, I talked to one of the largest employers in St. Louis, where I come from, and they told me that they have had to pay an additional $75 a month per employee in the last 5 years to maintain the same health care coverage available in 1979. That amounts to a yearly raise of $900 for every employee in that corporation for health benefits. Never in the history of the Republic, in the history of health care have we seen those kinds of increases in the private sector.

You and I are well aware of the situation in medicare and medicaid. Together they will cost $82 billion in fiscal year 1984. Between 1985 and 1989, outlays are projected to increase over 45 percent for a total bill of $135 billion. Some believe that by the end of the century, the total bill will be well over $300 billion in both programs.

While the Government is spending more in those programs, constituents continue to complain about the amount they have to pay out of pocket. The fact I want to give you now is one of the most impressive about what has happened with health-care costs. On average, the elderly today who are recipients of medicare pay out of pocket over $1500 a year to obtain health care. Now, listen to this. If you inflation adjust those dollars, it means that the elderly are paying out of pocket more today for health care than they were paying in 1964, the year before medicare was enacted.

So, even as we put $60 billion into a health care program in 1985 to help the elderly pay their health bills, the elderly still pay, in inflation adjusted dollars, more today than they paid out of pocket in 1964, before that important program, was enacted.

Three-fourths of the people in medicare that were recently polled felt that fundamental reform of the health care system was needed. One of the things that I think it is useful to look at is why these costs go up so remarkably. What is the cause of the explosion in health care costs?

There are four factors that I like to look at that I think are worthy of review. The first is technology. We all know that the NIH, rightfully so, is spending $4 billion a year on new ideas. Those new ideas have yielded wonderful new ways to both diagnose and treat disease, but clearly the technology is causing the costs to explode.

To just take one procedure, the Swan catheter, which is a wonderful new diagnostic procedure invented a few years ago, it is now used on millions of people a year. We believe the cost added to the health care system by that procedure alone is about $300 million in

the entire health care system. It leads us, I think, to question whether or not we have done enough research on when to use some of these inventions, but clearly, the inventions are adding to the cost.

Second is the volume, volume not only in terms of the number of people that are served but the number of times they are asking the health care system to do something. Part of the benefit of medicare is that we have 30 million people now getting health care on a more regular basis than before 1965, but in addition to that, there are more procedures and therefore more things being done, so the overall volume in the system has increased remarkably.

Third is the advent of malpractice claims and malpractice awards. I think clearly that there is some cause for review of the way malpractice works when you consider that only one-third of the malpractice awards finally wind up in the patient's hands. It makes one want to really take a hard look at what is happening in the malpractice system, but even beyond the awards is the effect it has on the behavior of physicians.

Last, I think that costs are exploding because of the structure of our health care system. I happen to believe it is an inefficient structure. I think that inefficiency comes primarily from the way we compensate for health care which I think causes it to be inefficient. We have separated the provision of health care from the compensation of health care. That is part of the inefficiency problem. Second, I think the doctors have not done as well as they could in figuring out what is high quality care. We are looking at studies now in Maine and Iowa that indicate that the variation in most diagnoses and most procedures is tremendous. We have seen variation rates, for instance, on hysterectomies within States, and other procedures, that go between 40 percent of the population and 20 percent of the population which leads us, I think, to begin to question whether or not we really have a grip among the physician community about what is the proper diagnosis and procedure rate with different kinds of situations.

To make a long story short, for all of those reasons, we have a cost explosion. The question is what do we do about it. As the previous testimony, I think, indicated, there are three alternatives. One is to raise taxes. If you are going to solve the medicare problem by raising taxes, we need to raise the medicare tax by 50 percent beginning next year in order to avoid the deficit in the program by 1990.

Second, we could cut benefits. If we cut benefits, we have to cut the medicare package by one-third beginning next year in order to solve that deficit problem. In my previous comment, I just said that we are already charging medicare recipients out of pocket more than they paid in inflation adjusted dollars before medicare was founded. If we cut benefits, it means they are going to pay even more, and I don't need to tell you what that would mean to the average medicare recipient.

The last thing we can try to do is to make the system work better, more efficiently, so that we can deliver high quality medicine at a lower cost or certainly at a cost that doesn't rise as much as it is rising now.

The Kennedy-Gephardt bill is really designed to aim at number three, to try to see if we can deliver health care in a more efficient way while we hold down costs. It sets financial goals for States. It asks States to reach those goals. They can either regulate or they can promote competition. They can do a combination thereof, but we want them to reach those goals in a 5-year period. If they have not reached those goals in 5 years, we go to a residual Federal system which, in essence, is an all-payers system. We say if what we have done in medicare is working, and appears to work in the classic fee for service system, why not apply it systemwide to achieve those kinds of savings and reach, and the important thing is to reach, those financial goals.

Third, it promotes health maintenance organizations and competitive medical plans. A lot of people have had, I think, concerns about competition. They have heard that competition will save money, but what will it do about quality? What are we doing to the quality of our health care system?

What we are talking about here is not competition between hospitals to fill their rooms. We are talking about competition between health maintenance organization-like entities, competitive medical plans, whatever you want to call them, but they offer annual fee for annula service, and they are competing not only on price but on price and utilization. Those are the key factors of the competitive approach that we stress.

So, we exempt from regulation competitive medical plans, health maintenance organizations, because we believe they have the potential to deliver a high quality product at the lowest possible price. They fuse the provision of health care with the deliver of health care, which is an essential component to getting a more efficient system.

Last, we ask consumers to choose between plans, and we reward them when they go to the more efficient, competitive plan. This is a very important concept and one that we need to stress. We can't just be telling doctors and hospitals that they have to have goals in terms of cost in our health care system. We have to somewhat aid them in that search by giving consumers the right signals so that they know if they choose a plan that fuses delivery with compensation that they will also be rewarded in that choice.

Let me conclude by saying that in my view this is the most important domestic problem we face. The medicare fund will be bankrupt by 1990. We have 30 million American people in the medicare system who depend upon us to see if we can make this health care system work. We cannot put off trying to reach for a solution until 1989. We have to either raise taxes or cut benefits or take the leap of faith to try to make this system work. I urge you to closely consider the provisions of our bill. I think it offers the chance to do that third alternative, and I urge you to consider enacting it as soon as possible so that we don't hit the wall in 1989 and don't have to face the choice of only two things, raising taxes drmatically or cutting benefits dramatically.

Thank you very much for allowing me to be here. I would be happy to try to answer questions.

[The prepared statement of Congressman Gephardt follows:]

TESTIMONY OF

Congressman Richard Gephardt

June 21, 1984

It is a pleasure to testify before the Committee on Labor and Human Resources about the problems facing the American health system. I have come to discuss those problems and a proposed solution that I have introduced with Senator Kennedy, the "Medicare Solvency and Health Care Reform Act."

The financial problems facing the health system are severe. Health care costs double every five years. That's an alarming rule of thumb, and it applies to the cost of health care for Medicare and for employers.

One employer in St. Louis has had to pay an additional $75 a month per employee to maintain the same health care coverage available in 1979. That amounts to a yearly raise of $900 for every employee for health benefits!

But, why should Congress care about increasing health care costs? Because the costs are bankrupting the government. Medicare and Medicaid account for ten percent of the Federal Budget. They will cost $82 billion in FY 1984. Between 1985 and 1989, outlays are projected to increase over 45% for a total bill of $135 billion.

While the government is spending more, constituents continue to complain about the amount that they pay out of their pocket. On average, the elderly pay $1,500 every year for needed health care.

Three fourths of those polled felt that fundamental reform of the health system was needed.

If we are to trim government spending, and meet the voters' needs for affordable health care, we are going to have to make changes in our health system.

The "Medicare Solvency and Health Care Reform Act," meets that test by making the health system more efficient. It moderates the cost of health care for the elderly and the working population. It allows states to develop their own strategy to reach the financial goals outlined in the proposal. States can rely on either a competitive approach or a regulatory approach. It promotes the development of health maintenance organizations and competitive medical plans. Consumers are asked to become informed and choose between competing health plans.

These provisions will provide powerful incentives for providers and consumder to hold down costs. Without them costs will continue to escalate, jeopardizing access and undermining Medicare.

Senator QUAYLE. Let me just ask a couple questions. You sit on the Ways and Means Committee there and are intimately involved in taxes and benefits, whether it be medicare or Social Security. I derive from your statement that you are basically telling us that you feel that the medicare insolvency that we stare at in the future, whether it begins in 1989 or shortly thereafter, can in fact be resolved entirely by a cost containment approach? Is that what you are telling us?

Mr. GEPHARDT. Do you mean the cost problem?

Senator QUAYLE. The cost problem, the third party.

Mr. GEPHARDT. I think it is very important that the Government tell the country or say to the country that we have to do something about this problem and that we have to set some goals and that we have to find the ways to reach those goals.

There remains disagreement in various States and various areas on how this should be done. Some States are moving on a regulatory front. Some States are moving with a more competitive approach. I am not sure there is one uniform approach that we can say is the best way to do it, but I think it is vital that we say, as a social and political matter, that this cost explosion has got to end, that we cannot simply put more and more of the GNP into health care or that we cannot just start hacking out, whacking out, benefits that people need and want in order to solve the problem. We have got to make the system work more efficiently than it has. We have to set those goals. We have to give people time to reach those goals in ways that they would like to try to do that, and then if that doesn't work, we have to call it a day and go ahead with a system that we are proceeding on, with the medicare program, which the jury is still out on but I think will yield some results.

At least, you finally say this is the end. We are not going to go any further than this. We want the problem solved.

Senator QUAYLE. There is obviously a political problem in that. As you well know, we have to convince not only those of us up here that are voting on things but the country at large and our constituencies to support the idea that there is a problem. Remember the Social Security thing we just went through that we resolved in 1983. I think the year before that a very large segment said there was no problem at all.

I think we ought to direct ourselves that there is a problem, and I certainly agree there is a problem, but again I want to get clear, are we going to go out, and as we say there is a problem, because I agree there is a problem, are you prepared to take the route in resolving this problem that we can resolve this problem through costs and cost containment solely, that we can do this without doing anything on the tax side and anything on restraining the growth of medicare? Is that the approach that you envision?

Mr. GEPHARDT. Let me say to you that consumers have a role in this. There is no question about it. They need to be sensitive to the costs of health care, but let me urge you to remember that they are there. If you go talk to any employer today, any employee, who is buying their health care, they know there is a problem, believe me. Every medicare recipient knows there is a problen. That is why so much is taking place in the field today. That is why so many efforts are going on to contain costs.

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I would urge you to understand that getting the economics of health care in a better situation is at least three-quarters of solving the problem, in my humble opinion. That doesn't mean that we as a government don't need to fund and do more research on the implementation of new inventions, on how to better standardize what is quality care, that we don't need to address the problems that are presented by the malpractice situation, that we don't need to be a help in unwinding some of those kinks in the system. But the main driving force of the cost is the way we pay, and we have to set some goals and we have to start trying to rationalize this system, either through regulation or through better competition, and that is the thrust of the bill.

Senator QUAYLE. I think that we have to make the system work. I was listening to your testimony, and the goals, I think, are essentially the same that I have as far as weeding out the inefficiency. You talk about, and have talked about in the past, making this more competitive. I think your premise is that by going to an all-payers type of provision that, in fact, you will get more competition, and by getting more competition then you are going to get a better and a lower and more efficient cost. I think that is the question we will have to ask a number of people that come after you. Will we, in fact, get more competition or will we get less competition by going to that?

Before you got to the cost element of solving the medicare problem, you went through basically four areas, the technology problem. And one of the pieces of legislation that we are promoting, and I think there is a movement over on your side as well, to do something with technology assessment which would deal directly with that problem.

You talked about the volume problem. I think that certainly an expansion and the efficient use of HMO's CNP's, PPO's, PPA's, would certainly be a way to deal with that.

The third area you talked about was defensive medicine, basically, malpractice, that we ought to take a look at this as far as the potential problems we have.

Finally, you ended up on the inefficiencies. Again, you are getting back to the competitive market, market forces.

The example that you used of that large employer in Missouri, and I have had the same discussion with a number of employers in my State as well, both large and small, and in the discussions I have always encouraged them, and they say that they have tried it but it is simply not there yet, and that is why I think that we ought to work to expand the HMO's and the CMP's and the PPO's. I say, look, you are a large buyer. You are talking about several hundred or even several thousand employees that you are going to insure. You have a lot of money there. You ought to go out and try to see what kind of a deal you can get and go into the market and try this out.

They say they are trying this, that they are getting more active in this. In the past, before they saw these costs just ballooning, they just said well, we will just sign up with the traditional way that we have always done business. Now that this is such a big item on the expense side, I find them being much more sensitive to

this problem. I would imagine the same this might apply to the example that you used in Missouri as well.

That is really what we are striving for. I don't think that our objectives are different. We really want to see those competitive forces work and make the system work, to use your words, but as your approach, before you got to the remedy for medicare, which I believe that you can do a lot on the cost containment, but I also believe, as I hope that the deficit down payment will reflect, that you are going to have to do some restraint of growth in the medicare program in various ways, whether it is the Senate approach or the House approach. That is going to have to be coupled with cost containment. I personally don't believe that you can achieve it through cost containment proposals.

However, those four areas are certainly areas that I think we ought to explore and amplify and see how we can achieve better forces that you describe and want to see.

Mr. GEPHARDT. Let me say two things. First, I just don't think that you can deal with the medicare problem by dealing with medicare alone. Medicare is about half of our health care system. As we have fooled with it alone in DRG's, what we have seen is an even greater cost explosion on the other side, on the private side. It is part of the reason that employers and employees are climbing the walls over health care costs. That phenomenon will continue and, in fact, get worse unless we try to deal with this on a system-wide basis.

If we try to go to the private side and just deal with it to heal Medicare, we would have trouble in Medicare. It seems to me that you have to have a system-wide approach. You have to set goals for the whole system and say this is what we want to try to hit. The key to Kennedy-Gephardt or the central idea of it is to say that we are going to reach those goals and we are going to give you lattitude on how to do it, but in the final analysis, if it is not done, we are going to regulate the fee for service classical side of medicine and we are going to try to give people the message that we believe HMO's, CMP's, PPO's, competitive health plans, where you fuse the provision and the payment for health care into one place is a way to get efficiently delivered health care. We want to try to say to people, let's move to that mode, but let's accelerate that movement and let's set a national goal that we are going to do something about health care costs, lest we wind up with 15 or 20 percent of the GNP going into health care costs.

Senator QUAYLE. I don't dispute that goal that we are going to have to do something about health care costs. The question that I have is that as we would move to right now to an allpayers system like that, whether you would really encourage more competition with the CMP's and the HMO's you refer to or whether in fact you would create less competition. I think that is the classical case of whether you are going to all of a sudden set a goal up here and a mark and they know that that is what they are going to achieve and then you are really taking away some of the market forces that I think are really building up. We have only had the DRG system for a year. It is a very short period of time. So, this whole health care problem is escalating. As a matter of fact, since we

have had that, you have seen an actual decline, at least on a comparative basis, from where we were before.

Senator Kennedy.

Senator KENNEDY. Just to reduce the time, maybe you would respond to this question about whether competition is going to be alive and well under our particular proposal and whether, if you use an allpayers system, you can still have incentives, competition, that will be incentives to the private sector and also incentives to the consumer.

Mr. GEPHARDT. Let's go right at that, because I believe that the bill encourages doctors and hospitals to move into competitive medical plans for the very simple reason that in the bill we exempt those kinds of organizations that offer annual fee for annual service where they worry about price and utilization. We move them out of either the State or the Federal regulation. So, there is a clear, direct message to those kinds of entities that if you want to avoid the problems of trying to be regulated, there is a way to go and that is where we want you to go because we think that is the most efficient delivery of health care.

So, I believe we have given the clearest, loudest message you can give as to what we want this system to move toward. The whole thrust of the bill is to get the system to change and to move and to be creative. We are not going to do that by standing around saying let's have a voluntary program. We tried it and it didn't work. We have to deliver a message and the bill does that. I say it would give you more competition. I say it would give you greater efficiencies and greater change within the private sector system between hospitals and doctors to get them to operate in a more efficient way.

Look, I will give you three States' per capita health increase in 1982: New Jersey, New York, and Minnesota. New Jersey and New York are two regulatory States, Minnesota a competitive State. New York was—I may not have these just right, but they were 6 to 9 percent increase. I think New Jersey was 12; I think New York was 7 or 8. Don't hold me to it; I will get it for you. Minnesota was 4 percent. They have a third of the people in the State, including medicare people, in the health maintenance organizations. The utilization is about a third of the classis system. I say that the health outcome is as good if not better for the people that are in those programs.

The point I am trying to make is that if we can get the system to move in that direction more quickly, I think you provide some real answers in terms of both cost and quality.

Senator KENNEDY. Let me ask you, Senator Quayle asked this question and I would like to make sure that we agree, and that is, if we implement this program, whether, first, the medicare system is going to be financially sound to the year 2000. Over on my right, your left, there are the figures which reflect that by the year 2005 that actually the medicare system would be in surplus by $165 billion. These figures, as the Congressman understands, are based upon the same assumptions that were used under the medicare trustees and run through the computers out at the Georgetown Health Research System using our particular program.

So, if you implement it, we find that the medicare trust system is in surplus. I would be interested whether the Congressman would

agree that the other chart, on your left, would indicate that the private savings would be some $74 billion and that the savings on the deficit, which is also the last chart over here on the end, would be a reduction in the deficit by some $30 billion. So, we have a reduction in the deficit, we have savings for the private consumers, we have the medicare system in surplus to try to deal with some of the other needs of elderly people, on drugs, on dental care, eye care, foot care, the enormous needs of our elderly people, and without the reduction in terms of benefits for the increase in terms of taxes.

Mr. GEPHARDT. The Senator is absolutely right. Let me make one other point. We are going to face, in 1987 and 1988, the need to raise taxes tremendously or cut benefits overwhelmingly to solve this problem. Obviously, we will do that to one extent or another.

In doing that, we will have done nothing about the 20 to 30 million people in this country that have no coverage whatsoever, people who don't have medicare, medicaid, or any private insurance. We are not addressing their problem in any way. As we increase the price competition and the price concern, the hospitals in the inner cities are going to stop taking the indigent patients they have been taking in the last 25 or 30 years. We are going to have a major moral problem in this country of what we are going to do about indigent care. We are not going to have any way of paying for it, not even a hint of a way to pay for it.

So I say we have got to pass legislation like this next year, get on with solving the problems in medicare and the private side so that we even have the chance to address that problem.

Senator KENNEDY. Let me ask you, how do you respond to the statement, and I am sure we are going to hear it frequently during the course of these hearings, that we should just leave it up to the employers' and the providers' initiatives and that is going to solve the problem. Do you see a dip in terms of the increase in health care costs in this last quarter and is this really where it is going now if we leave it up to these groups and let them work it out and keep your hands off our health care system?

Mr. GEPHARDT. That is what I said in 1978. It didn't work. It is not going to work. There will be some improvement. DRG's have helped. Doctors and hospitals are talking to one another. Behavior is changing, but those cost figures, even the latest ones, do not show that much of a decrease. The cost increases are still double and triple the rate of inflation and inflation is down, so that is part of the reason costs have gone down.

The underlying inefficiencies in the structure of this system have not been changed and will not be changed until we get serious about doing something about it.

Senator KENNEDY. I just have a final question. Why, if we don't accept this system, why aren't we really getting into a system of rationing health care? We will hear that, I am sure. Won't we find out that under the budgetary kinds of restraints that you talk about here, won't this result in the rationing of health care if we put prospective budgeting in? What is your response to that?

Mr. GEPHARDT. We are rationing health care now. We have been rationing health-care ever since we had a health care system. The question is, how do you ration it? How do you rationalize it? And it

seems to me that it has been irrational to have increases of this magnitude. It is irrational with respect to the budget and it is irrational to the people that don't even have health care because no one can afford it.

I just say to you that the rationing that would go on under this kind of a program would be more rational than what we have today.

Senator KENNEDY. Thank you very much.

Senator QUAYLE. Certainly.

Senator Grassley?

Senator GRASSLEY. Mr. Chairman, I have a statement that I would like to put in at this point, and I have no questions of this witness. I want to thank him for his time here. I am sorry I didn't hear all your testimony, but I do have access to it and I had some questions that have already been answered.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR GRASSLEY

I think that the subject the committee is taking up in this hearing today—health care cost inflation and strategies for its containment—is probably one of the more important issues now on our public policy agenda.

A perception that increases in health care prices have been unjustifiably great in recent years has led directly to political demands for a national health care cost containment strategy. These political pressures have stimulated a number of important recent initiatives to curb increases in health care prices, such as the prospective payment system for hospitals and the several new ways of organizing and delivering health care which are being tried around the country.

These initiatives do seem to be having some effect. Although the medical care price index has been increasing faster than the general consumer price index, it has been increasing more slowly in recent months than it was earlier. Hospital utilization has also begun to fall dramatically.

Nevertheless, many observers and participants in our health care system continue to argue that we will sooner rather than later have to move forward with some sort of more thorough-going cost containment strategy, whether this be the incremental, competition approach favored by some, or the public utility approach favored by some others. So far the debate seems to be not so much over the question of "whether", but rather over the question of "how", and perhaps "when", we will move forward.

And in connection with this question of how we proceed with a cost containment strategy, I think that the hearing record should include some description of a cost containment effort currently underway in Iowa. I ask that a recent article in the New York Times of June 14, 1984, about this initiative be included in the record with my prepared statement.

In Iowa, the pattern of medical and hospital care has been changed dramatically by a unique, State-wide cost containment strategy developed and supported by a cooperative, voluntary private-public coalition of unions, employers, the State government, the health care industry, and private health insurers.

The approach being used in Iowa features, among other things, agreement among the participants to deemphasize expensive types of care and long or frequent hospital stays. The strategy also features a unique project which provides data on the price charged by different providers for major medical procedures. This data allows employers and health plans to negotiate more intelligently with health care providers.

One of the first results of this coalition's activity has been a five percent reduction in health insurance rates for some 330,000 Iowans. Another major result has been a dramatic drop in hospital utilization.

This activity in Iowa is probably not unique; I think some of our witnesses today will tell us about similar activity underway elsewhere. It is probably also the case that this recent experience with voluntary, competition approaches will not settle the issue of what is the best approach to health care cost containment in this country. And, since the results are only beginning to come in, it cannot really settle the issue.

Nevertheless, I think that the experience in Iowa shows the potential of such voluntary, joint public-private responses to the need to curb health care cost inflation without at the same time sacrificing quality of care, access to care, and freedom of choice within the system.

If Congress runs true to form, any major steps will probably be postponed until the financial collapse of the Medicare Hospital Insurance Trust Fund is almost on us in 1990. That does not give us much time. Clearly, given the difficulty of achieving consensus on appropriate reforms and putting them into place, the time that remains must be wisely used to continue public discussion, to try to develop enough of a consensus to move forward in a way that curbs costs, maintains high quality, open access and freedom of choice. It may be very difficult to preserve all of these, but that is what we should try to do.

I am looking forward to the contributions that our witnesses today will make to this debate.

Iowa Plan to Lower Health Care Fees

By MILT FREUDENHEIM
Special to The New York Times

DES MOINES — The first general reduction in health insurance rates since double-digit inflation took hold six years ago will go into effect in Iowa at the end of June. Experts say the reduction, a result of an innovative statewide plan, is setting a national pattern in combatting rising health costs.

Under the plan, health insurance rates for 330,000 Iowans will go down 5 percent, a $24 million reduction that is getting close attention in Washington and around the country, where rate increases of 15 to 30 percent are still the rule.

Blue Cross and Blue Shield announced guidelines to help control the costs of diagnoses. Page B28.

The reduction, based on a significant decline in the use of hospital beds, is the first fruit of a three-year combined effort by employers, unions, the state government and the health care industry. The plan is based on controlling costs through such strategies as de-emphasizing expensive types of care and long or frequent hospital stays in favor of outpatient care or treatment that can be administered in physicians' offices.

Donald P. Rowen, a leading participant who is executive vice president of the Iowa Federation of Labor, calls the plan "an experiment to see if competition within the system will work."

Similar coalitions have been established with varying effectiveness in 150 communities around the country.

"Employers who are paying the bills in Iowa and other parts of country are starting to realize that they have the opportunity to exercise some control over health care costs," said Bruce Steinwald, acting director of health policy in the office of the Secretary of Health and Human Services in Washington.

"The actions in Iowa and the result they've achieved constitute a dramatic example of a national trend," said Bernard R. Tresnowski, president of the national Blue Cross and Blue Shield Association, the nation's largest health insurer. "Blue Cross and Blue Shield plans in 50 states are initiating a variety of cost-containment strategies. The results are adding up to an overall decline in the use of the most expensive types of care and an increase in lower-cost alternatives such as care in outpatient departments and physicians' offices."

Three years ago the use of Iowa hospitals was growing faster than in most states, and costs were rising faster than 30 years, according to the American Hospital Association's latest figures. Hospital costs are still rising, but the growth rate is slowing. The costs increased 10.2 percent last year, 14.9 percent in 1982 and 17.5 percent in 1981.

Blue Cross plans in Connecticut, Cleveland and Kansas City are cutting back projected rate increases, but only Iowa's rates are going down, spokesmen for the associations said. Blue Cross and Blue Shield of Greater New York, with eight million subscribers in the metropolitan area, said that monitoring of costs and use saved $140 million last year. New Jersey Blue Cross said similar programs had brought a continuing decrease in inpatient hospital use there.

"Doctors were putting too many people in hospitals, keeping them there too long and running too many tests," said Glenn Witt, staff vice president and personnel director of the Meredith Corporation, a Des Moines-based magazine publisher and television chain. "Since 1970, our health costs have doubled every five years."

Iowa's prosperous physicians have gone along with the changes.

"We haven't taken an adversarial position," said Eldon Huston, executive vice president of the state medical society. Physicians run the Iowa Foundation for Medical Care, which reviews hospital admissions and treatment for Blue Cross-Blue Shield and private employers.

Study Group Organized

Worry about the state's shrinking tax base and its growing elderly population made controlling costs a priority. Mr. Sibery, who came to Des Moines from the Greater New York Blue Cross plan, started a review of hospital use in 1981. Under the rules, insurance payments for a hospital stay are not approved until less-expensive alternatives such as care in a physician's office or a clinic are ruled inappropriate by advising physicians.

In 1981, business leaders also persuaded Gov. Robert D. Ray to appoint the 11-member Commission on Health Care Costs. Its recommendations are being carried out by the Health Policy Corporation of Iowa, an independent planning agency headed by representatives of business, labor and state government.

"We are building a system based on market forces, as an alternative to Government regulation," said Paul M. Pietzsch, the agency's president. His group persuaded the Legislature to establish a Health Data Commission, which published comparative hospital charges in May for the 25 most frequent procedures. The commission also plans to issue a comparison analysis of physicians' charges.

The information will be used by employers and health plans negotiating with hospitals and physicians. Some large groups in other states are forcing hospitals to give discounts in return for an assured volume of patients, under a system known as preferred provider arrangements.

[In the Blue Cross-Blue Shield plan announced Wednesday in Washington by Mr. Tresnowski, an educational effort would be used to persuade doctors not to use certain procedures, and at some future date payments would not be made for those disapproved procedures.]

Carrying out another recommendation of the Commission on Health Care Costs, the Legislature ended hospital and physician control of Blue Cross and Blue Shield, giving consumers two-thirds control.

Catering Is Attempted

The squeeze has left many Iowa hospitals half empty and hurting financially. A hospital in Davenport is selling laundry and catering services to outsiders.

"Our challenge is to down-size with minimum trauma, while maintaining accessibility in hospitals and doctors in the rural areas," said Michael V. Reagen, the state's Human Resources Commissioner.

[illegible] departments and physicians' offices."

Three years ago the use of Iowa hospitals, measured in patient/days, was well above national norms, and rising expenditures for Medicaid and health coverage for state employees were straining the state budget.

'Changed the Pattern'

"We have changed the pattern of medical and hospital care dramatically," said Donald W. Dunn, president of the Iowa Hospital Association.

In the first three months of 1984, patient/days dropped 3 percent more as hospitals began observing Medicare payment ceilings under a new system: Instead of billing for care provided on a case-by-case basis, the hospital is paid a fixed amount for each case, depending on which of 467 specified diagnoses it comes under.

Mergers and closings of some of Iowa's 128 acute-care hospitals are widely predicted.

The 5 percent rate decline in rates applies to individuals and groups of fewer than 25 people, said D. Eugene Sibery, president of Blue Cross and Blue Shield of Iowa. This amounts to one-third of the one million subscribers in the state. In addition, 100,000 Iowa Farm Bureau members got a 2 percent reduction. Iowa's economy is rooted in agriculture, but 70 percent of the 2.9 million population live in or near medium-size cities. Health care in the state costs $7 billion a year.

Nationally, admissions to hospitals fell in 1982 for the first time in more

Mr. GEPHARDT. Thank all of you very much. I appreciate it.

Senator QUAYLE. Thank you, Congressman Gephardt.

Next, we have Edgar Davis, Jeffrey Joseph, Gerald Greenwald, and Candince Owley.

What I am going to do is to ask this panel to summarize your statements and limit them, if you will, to 5 minutes so we will have sufficient time for questions and so we can get through everybody. We have six panels today.

The first witness is a familiar face to me, Mr. Davis of Eli Lilly. It is good to see you again. You have been very helpful to me on the Advisory Committee on Health Issues.

The committee will come to order. Those people talking will cease conversation now. The committee will be in order.

Mr. Davis.

STATEMENT OF EDGAR G. DAVIS, VICE PRESIDENT OF CORPORATE AFFAIRS, ELI LILLY & CO.; AND CHAIRMAN, TASK FORCE ON HEALTH STAFF, THE BUSINESS ROUNDTABLE

Mr. DAVIS. Thank you, Senator.

I have, as you know, submitted a much more extensive written statement for the record. I hope that it will be printed in its entirety in the record, and I hope that the analysis contained therein will be of interest and assistance to the committee.

We of the Business Roundtable, of course, appreciate the opportunity to be here; and we commend the committee for bringing together representatives of so many of the organizations that are vitally concerned with the cost and quality of health care, because it is time to pause and thoughtfully consider current developments, not history, before we assess the need for further legisislation or central action.

The crux of the debate, of course, as it has developed in recent months and it has clearly been presented before the committee today, is between expanding Government regulation of health-care prices beyond that mandated by the Medicare Amendments of 1983 and relying on private sector initiatives. The first strategy looks to Government-established uniform price controls or goals to regulate such prices as physicians' fees, outpatient charges, and nursing homes. The alternative strategy looks to expansion of the various initiatives that business, providers, labor, and insurers have undertaken over the past several years.

I would like to note, however, that the private sector initiatives, which you have asked me to talk about today, Senator, differ, in my judgment, substantially in a very important regard from the so-called voluntary effort that has been referred to here earlier this morning—that is, for the first time in recent history, to my knowledge, unlike the period of the Carter administration, purchasers of health care have become highly motivated to challenge and constructively work with providers. The voluntary effort that I recall was one based upon voluntary action by hospitals and physicians, but the purchasers of health care were really relatively silent observers in that process. That is not the way the world is today.

Furthermore, I think that the majority of the private sector is just not ready to throw its hands up in the air and say that we

can't do our job, there is nothing further that can be done, and there is just no alternative. For that reason, the Business Roundtable, in 1981, established a health initiatives program to assist each of its member companies. It was aimed at essentially six primary objectives. I will touch on them very briefly. They are elaborated on in more detail in my statement.

They include the development of a data base on health care claims in order that the purchasers of health care, as well as their insurers could be more informed about prices, utilization review, et cetera. I want to stress this because this goes to the question, in my judgment, of, How can we rely upon the private sector actions today to be any more productive than they were in the past? In my judgment, one of the primary answers is the significant new technology—computer technology, information technology, all kinds of sophisticated managerial analyses—that is being brought to bear by highly competent staffs, and corporations, insurance companies, and other places to get a better understanding of what we are spending our money on. What are we getting for our money? What are the variations in the patterns of payment and why are those variations there? Can we justify them from our own analytical base and, if so, then, are we willing to pay for them?

Our second key point in our program is making health care benefit packages more cost effective. We have worked hard, through utilization review, through analysis of claims information, through adjustments of benefits programs, so that people don't go to hospitals for things that they could achieve at a lesser cost with equal quality outside of the hospital.

We have been working hard at promoting health, disease prevention, and safety programs. In the short run, those add to costs because they involve the construction of facilities or expenditures on prevention programs. But we believe they are not expenditures, Senator—we believe they are investments. We believe it is important to consider total health costs in the context of how much of that is an investment in the productive and elderly segment of society to continue to be creative and productive throughout their lives as opposed to simply expenditures for maintenance of health.

We have been concentrating on reviewing and evaluating health-care benefits, finding ways to persuade our employees, and patients, and providers to use the system prudently. It is a good system. It has taken a lot of time to build it. It has its flaws and its warts; but if we learn how to use it prudently, in our judgment, we can make some good progress.

The fifth key point in our program is that we encourage our corporate executives to serve as trustees of hospitals and other institutions, so they can bring their business judgment and experience to the consideration of the health issues and budget alternatives that come before the boards.

And, last, we participate in the leadership of health-care coalitions formed in communities in which we work and live. We believe that business leadership can stimulate communitywide approaches to providing health care for the needy and indigent that is also of a quality and cost-effective nature.

I want to report very briefly on some very positive results since 1981 that our group has recently published. Copies are attached to

my statement. A good number of our roundtable companies have implemented an increase in reimbursement for ambulatory services; 82 of our firms now audit the claims much more closely. More than half of our firms offer alcohol- and drug-abuse counseling. Nearly half of our firms provide on-site physical fitness facilities at selected sites.

In other words, we are trying to make sure that the money we spend is well spent. It may be that in the future the size of our work force will require increased expenditures, but we are not averse to increased expenditures if they are soundly based and based on quality.

In summary, again I would like to direct your attention to our written statement. I would emphasize the fact that we in the private sector recognize that public funding of health-care programs reflects the Congress' view of what is essential for the elderly and others in need in the population. In the same sense, those of us in the private sector are developing social contracts with our employees in terms of what we and they believe to be appropriate to their health and welfare for their productive and retirement life. The freedom that we have in the private sector to shape that and to accept increases in health-care expenditures, if we are convinced they are appropriate, is an essential freedom to us in the private sector. We believe our efforts to date to control costs are beginning to show results.

You know that the most recent statistics from the Business Roundtable have indicated that our member companies, in the first 3 months of 1984, have experienced rates of increase in their health program costs per recipient that are significantly less than those of 1 year ago. While they are still greater than we would like to see them, we are confident that the efforts that we have under way in the private sector will show a continued reduction in the rate of increase.

I will be glad to answer questions.

Thank you.

[Response to subsequent questions and the prepared statement of Mr. Davis follow:]

MR. DAVIS' RESPONSE TO QUESTIONS SUBMITTED BY SENATOR HATCH

1. Have government regulations contributed to increasing health care costs? Do you feel that further regulations will help reduce costs?

   Government regulations have contributed, and continue to contribute, to increasing health care costs. We feel that further regulations will add to health care costs and will not help in reducing costs. Solid evidence from studies of the pharmaceutical industry substantiates the cost-increasing characteristics of regulation--for example, see Henry Grabowski's "Public Policy and Innovation: The Case of Pharmaceuticals," Technovation (Vol. I, 1982, pages 157-189).

2. How are employers dealing with increasing insurance premium costs and the pressure to expand employee health coverage?

   Employers are taking general actions to increase employee and public awareness of current health benefit utilization and to examine the design of present and future benefit plans. In addition, employers are acting in several ways to withstand the pressure to expand employee health coverage--for example, making employees aware of how costly health care has become and how it is in the employees' own interest to keep these costs down. The development of wellness and fitness programs is another way that employers can ease pressures to expand health coverage. In terms of increasing costs, we see employers implementing many actions to deal with increasing health care costs and, therefore, insurance premiums. Many of these actions were outlined in my testimony and in our publication that accompanied that testimony--"Private Sector Initiatives and Health Care Costs" (see pages 11 through 13).

TESTIMONY BEFORE THE

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

by

Edgar G. Davis

Chairman, Task Force on Health Staff
The Business Roundtable

Vice President, Corporate Affairs
Eli Lilly and Company

Washington, D.C.

June 21, 1984

My name is Edgar Davis. I am vice president for corporate affairs of Eli Lilly and Company and chairman of the Task Force on Health Staff of The Business Roundtable. As you know, The Business Roundtable is comprised of approximately two hundred of the chief executive officers of the nation's largest corporations. I appreciate very much this opportunity to discuss with you today what the Roundtable believes is the most appropriate strategy for health care cost-containment and what it is doing to encourage the many activities taking place across the nation to reduce the costs of health care without impairing the high quality of care and the effective delivery of care that the American people want and deserve.

The crux of the debate, as it has developed in recent months and as it is presented by the witnesses before this committee, is between expanding government regulation of health care prices beyond that mandated by the Medicare amendments of 1983 and relying on private sector initiatives. The first strategy looks to government-established uniform price controls to regulate such prices as physicians' fees, outpatient charges, and nursing homes. The alternative strategy looks to expansion of the various initiatives that business, labor, providers, and insurers have undertaken over the past few years.

In my statement to the committee, I would like to review some of the private sector initiatives and offer some very recent survey data as to their effectiveness. I would

then like to discuss the fundamental reasons why not only the health of the nation but the strength of the economy and the relationships within our society would be better served by a cost-containment strategy that relies heavily on private sector initiatives and utilizes government controls only for publicly financed health programs.

For many years, as you know, the price of care has risen at a rate faster than the cost of living generally. This was especially true during most of the years of very rapid general inflation from 1977 to 1981. There were many reasons for this: a rapid rise in labor costs, which account for as much as 65 percent of the cost of institutional care; massive increases in malpractice insurance costs; the use by hospitals and physicians of very useful, but expensive, technology; the prevalence of third-party payment systems, which insulated patients from the need to make cost-conscious decisions about care and isolated much -- but not all -- of the health care sector from the free market force of direct price competition; the impact of general inflation, such as higher interest rates, on financing of capital improvements by both nonprofit and proprietary hospitals; and large increases in the bills for food served to patients, heating, and air conditioning.

These trends became of increasing concern to business firms, which account for 25 percent of total health care spending -- over $60 billion a year -- through their employee

benefit and retirement programs. Health care was becoming one of the largest, and fastest-growing, cost items in the corporate budget, and there was a great deal of discussion in many corporations about the possibilities of gaining a better awareness of the forces behind health care cost increases and taking constructive steps to manage our health care bill. We accepted the challenge of formulating a private sector approach that would bring sound management practices to bear on an area of costs that had not received proper attention in all cases. While many individual companies and business associations have been working on the health care problem, The Business Roundtable constructed its own effort in 1981 and enlisted its members to give priority attention to this important subject. Our program is entitled, "An Appropriate Role for Corporations in Health Care Cost Management," and was formally announced about two years ago, as described in a booklet of the same name.

Let me make it clear that no corporation can look at health benefits purely as a cost item. They are not like inventory purchases or capital spending, to be raised or lowered with the volume of sales or the company's prospects. Nothing is more important to American workers than their personal health and the health of their family, friends, and neighbors. To the extent that employers can enhance health, it is to their benefit as well as to that of employees. If a new diagnostic machine can find a tumor that otherwise would

be undetected, if a new drug can cure an illness that otherwise would keep an employee out of work, if an insurance package can spare a breadwinner the financial burden and the anxiety of major illness, it means higher productivity and higher morale and benefits everyone -- the worker, his or her family, the company, the nation. That is why the business community and all of us have been determined to meet this problem in a way that does not compromise the high quality of health care our people today enjoy.

More than two years ago The Business Roundtable joined with the Health Insurance Association of America, the American Medical Association, the American Hospital Association, the AFL-CIO, and the Blue Cross/Blue Shield organizations to encourage the formation of local health care coalitions. We stated our belief in the cooperative, local approach to containing health care costs. All these organizations agreed to help communities identify their health needs, educate their citizens about cost-effective care, help institutional providers develop better management systems, and undertake pilot programs to reduce costs without affecting care.

At the same time, the Roundtable organized its own program on health, which now includes 161 member companies with 13 million employees, 5 million retirees, and more than 30 million dependents here in the United States. This program assists each of our member companies in six ways:

1. to develop its data base on health care claims, so that it will have the same level of information in purchasing health care services that it has in purchasing the other goods and services it buys.
2. to make its health care benefit packages more cost-effective, through utilization reviews and thorough-going analysis of claims information.
3. to promote health programs, disease-prevention programs, and safety programs within the company, so that each employee will be encouraged to take personal responsibility for his or her health and healthful lifestyle.
4. to review and evaluate its health care benefits and find ways of persuading both patients and providers to use the system prudently.
5. to encourage its corporate executives to serve as trustees of hospitals and other institutions, so they can bring their business judgment and experience to the consideration of the health issues and budget alternatives that come before the boards.
6. to participate in the leadership of health care coalitions formed in communities in which we work and live. We believe that business

leadership can stimulate community-wide approaches to providing health care for the needy and indigent that is also of a quality and cost-effective nature.

This was an extensive and ambitious private sector effort. Its full results will take some time to unfold. But, based upon our recent survey of our member companies, the Roundtable believes that important progress has been made. According to our reports, design of benefit plans to encourage prudent use of health services is widespread. Fifty percent of Roundtable firms have recently increased cost-sharing. Some firms are changing the rate of reimbursement to encourage workers to use services that substitute for inpatient hospital care. For example, 22 percent of our firms have implemented an increase in reimbursement for ambulatory surgery. Eighty-two percent of the firms audit health claims to verify the eligibility of the patient, determine the accuracy of the claim, or review the appropriateness of the service provided to employees and dependents.

The most predominant form of health promotion in our firms is the physical examination, which screens employees for possible health problems. More than half the firms in our survey offer alcohol and drug abuse counseling. Over 40 percent provide on-site physical fitness facilities at selected sites to encourage exercise. Employee health is a matter of concern for most Roundtable firms, regardless of the

state of the economy. For example, at least 73 percent offer employees total health coverage even if they are laid off, up to an average of eight months.

In the past few days our Task Force on Health has released an encouraging report entitled, "Private Sector Initiatives and Health Care Costs." I would like to insert at this point a few paragraphs from that report which indicate that the rate of growth of spending for health care is going down:

> "In recent years, spending for health care has increased more rapidly than spending for many other goods and services. However, there is growing evidence of a significant decline in the rate of health care spending. For example, the annual change in total personal health care spending in the United States is estimated at 10.1% for 1983, a 2.6 percentage point reduction from the 1982 level of 12.7%. This reduction in growth of health care spending for 1983 over 1982 occurred while the growth in gross national product nearly doubled over the same period. Similarly, growth in spending for hospital care was 4.1 percentage points less in 1983 than in 1982.
>
> "Other data also confirm the downward trend in the growth in spending for hospital health care. For example, in 1983 the length of stay for patients in hospitals declined, particularly among patients over age 65. Further, the number of hospital admissions declined slightly, as did the percent of occupancy in hospitals nationwide. The rate of increase in hospital revenue per admission declined 5.8 percentage points from 1982.
>
> "Other data also illustrate that the gap between the price index for medical care and the price index for all goods began to narrow dramatically during the first half of 1983. Reasons for the slowdown in health care spending probably can be attributed to several factors:

1. The slowing general inflation in the overall economy.

2. Anticipation of the effects of changes in the government's Medicare reimbursement procedures for hospitals.

3. The effects of the actions of major purchasers of health care, including most Business Roundtable companies, to find ways to slow down the growth of health care costs.

"In regard to the latter point, most Roundtable companies believe their own activities have been successful in achieving some reduction in the costs of their own employee health plans over what they would otherwise have been. These company initiatives have included a variety of approaches, such as the redesign and strengthened administration of employee health benefit plans, the encouragement of alternative delivery systems in the communities in which they operate, and their participation in community groups concerned with health planning activities of all kinds.

"To determine whether corporations have experienced moderation of health cost increases similar to national trends, the Business Roundtable Task Force on Health recently polled Roundtable companies about their health costs. The results indicate that, for many corporations, changes in health costs have paralleled national trends.

"For example, for the first quarter of 1984 compared to the first quarter of 1983, responding firms experienced an average increase in health costs per recipient of the health plan of about 9%. In comparison, these corporations reported an average increase in health costs per recipient of 13% for the last six months of 1983 compared to the last six months of 1982. Therefore, it appears that corporate experience has been analogous to national trends of slower growth in health costs."

The work of the business community is making a significant contribution to the literal explosion of activity in the private sector aimed at reducing health costs. You see it everywhere: in the growth of health maintenance organizations, which now enroll 15 million people; in the growing use of preferred provider organizations, which offer volume purchases of health care services to corporations and health insurers; in the ambulatory surgery centers appearing up and down Main Street; in the proliferation of urgent care centers, wellness centers, sports medicine clinics, neighborhood health clinics, home health care programs, mental health centers, and rehabilitation and long-term care programs; in the voluntary actions of doctors, through their professional societies, to put a cap on fees; and in the massive efforts by hospitals to eliminate unnecessary costs and market innovative health programs. There is no segment of the health care industry that has not been impacted by this nationwide commitment, that is not sensitized by now to hold up each of its activities and each of its decisions to new standards of cost-consciousness.

It is obvious from this list of activities that the entire health care industry is in a period of flux and rapid adjustment. New ideas and new approaches are as plentiful as the number of individuals and organizations that are working to contain health care costs without compromising quality or access to care. We are seeing how a dynamic, competitive, and pluralistic segment of the national economy rises to an

obvious need. Not all of these activities will succeed, but those that do will be adopted across the country. The prospects of successful cost-containment for this strategy are far greater than if we were to leave the job to a government agency, be it state or federal.

You will notice that these results, as well as the references to medical care prices, are couched in terms of a slower rate of increase. Although the differential seems to be narrowing significantly, the overall cost of health care is still rising faster than the cost of living generally.

Of course, the temptation is to assume that there is so much fat in the system that we can solve all of our problems by having government determine what services will be provided, at what price, and to whom. In fact, the gap between health care costs and the general Consumer Price Index that has persisted for a number of years now is caused, in overwhelming proportion, by increases in the cost of items over which the providers of health care have no substantial control.

- Of the increase in total health care expenditures between 1972 and 1981, 9 percent was caused by an increase in the population; 27.4 percent, by increased per capita use; and 63.6 percent, by increases in prices.
- Of the increases in the price of health care goods and services, which account for the lion's share of

the increased expenditures, only a very small part can be traced to inflation in the price of health care goods and services themselves. Ten times as much is the consequence of general inflation in the economy, brought on by a combination of government, monetary, and fiscal policy actions, with some additional contribution from structural changes of the economy, economic shocks of the business cycle, and international events -- all causes outside the control of any particular economic sector or industry.

- Of the inflation specifically attributable to the health care industry, almost all can be traced to increased hospital unit-labor costs, increases in malpractice insurance for hospitals and physicians, increased food and utility prices, and the growth in clerical workloads created by government and private insurance-payment systems, with labor costs by far the largest item. In this connection, it should be noted that it is much more difficult to increase productivity in a health care institution than in a factory, since what is being measured is not a product but a service. A factory can increase productivity through automation without affecting the quality of its goods. It is probably not reasonable to expect a hospital to increase productivity to the same dramatic extent, since the

service it provides is, essentially, care for its patients. Of course, productivity improvements are possible in hospital services and many other service activities, but the historical range has been about 1-2 percent annually, compared with 2-3 percent for the entire economy.

These considerations have one primary implication for health care price-control policy, whether attempted through public or private means. If price controls had effectively eliminated all specific inflation and had done so with absolutely no direct or indirect social costs, it is estimated that the net benefit in 1981 would have been a reduction of only 4.7 percent in the total national health care bill, and little more than that in subsequent years. Even if such inflation beyond that expected through wage increases and productivity increases in the rest of the economy could have been achieved, it would have been at the expense of the catch-up in wages in hospitals and other health care institutions.

A noteworthy paper[1] detailing these facts and figures was published in the spring, 1984, issue of Health Affairs. The complete paper is appended to my testimony.

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[1] Authors of the paper are Dr. John R. Virts, corporate economist of Eli Lilly and Company, and Dr. George W. Wilson, associate professor of economics at Central Missouri State University.

Providers and purchasers of health care in the private sector do not believe that one solution will solve the problem. We in business applaud this diversity. We believe that the balance between quality, access, and the cost of care -- at least in the private sector -- is best struck by stimulating market mechanisms that encourage experimentation and alternative approaches.

I would like to give you some observations about what this means for public policy, for that is your primary concern. Because we are a pluralistic society, our approaches to reshaping the health care system can clearly vary between public and private sectors. In the public sector -- which is, of course, the smaller of the two in terms of spending -- government regulation is the traditional tool. Reshaping the system there takes the form of political budgeting of Medicare and Medicaid programs, as well as changes in how these programs work, such as the new fixed-price controls, or DRGs, on hospitals.

The cost-control strategy of some of the legislation now before the Congress clearly envisions rigid government price controls and other regulation of both public and private sector health care at either the federal or state level. On the other hand, we are encouraged by the concepts in Senator Quayle's recently proposed legislation that are designed to remove impediments to the formation of preferred provider organizations in the public program.

We believe that reshaping health care in the private sector takes a different -- and, to us, a far more effective -- form. In the private sector the sources of health care financing are the hundreds of employer benefit plans and insurance-carrier benefit packages, crafted to meet specific needs and freely selected by individuals. Employer health benefit plans have, over the years, become both entitlement programs and social contracts. They reflect management's desire to maintain relationships with employees that encourage productivity, job satisfaction, and high morale. Reshaping such relationships through government dictation runs a high risk of damaging these delicate relationships that are so important to the prosperity of your local economies.

In the long run, the really significant savings in health care are going to come from innovation, spurred by the forces of the marketplace. This is one key factor in the way in which life expectancy in this country has increased by more than twenty-five years so far in this century. This is how we have developed new drugs, better medical devices, and better surgical techniques that cut down not just on length of stay but on the need for hospitalization altogether. If we really want to reduce the total cost of illness as well as the cost of care, we must be careful not to impose regulation that stifles the system of innovation and competition that has served us so well.

I would like at this point to discuss some of the criticisms that have been made of a strategy that depends upon private sector health care coalitions as a means of community management of health care matters.

It has been said that, if a problem is approached through the leadership of the business community, its employees, and providers, it will ignore low-income groups and the unemployed. I would like to point out that, when the major labor, provider, and insurance organizations joined with the BRT in 1982 to urge the formation of local coalitions, we committed ourselves to improve the quality of and access to care for these groups. In our initial statement we said:

> "We view the most appropriate focus of local coalitions generally to be the cost of delivery of medical care . . . with related attention to the quality of care, the availability of proper medical care, and access to such care by various groups within the population."

In urging coalitions to undertake analysis of local health systems, we said:

> "A key area of analytical concern should include existing health care facilities and services in the community with an assessment of the availability of needed services, <u>especially for the disadvantaged and unemployed</u>" [emphasis added].

As far as we can ascertain, these original commitments are being honored.

The argument has been made that, if business firms and insurance carriers contract with preferred provider organizations, the poor and the needy will again be excluded

and that only government-established uniform price controls can guarantee their access to quality care. Yet there is no evidence that the cost-control actions stimulated by government regulation make any better provision for indigent patients than those stimulated by voluntary efforts. The problem of adequate care for the needy is one that varies by locality. One locality may have an adequate municipal hospital system; another may have to work through referrals and neighborhood clinics. In addition, there are extreme dangers in government- established uniform price controls in the sense that results may be at the expense of lowering the quality of care for everyone. The problem can best be solved by local efforts cognizant of the special problems of indigent care and the special obligation we all have to deliver it.

A number of arguments have been made in favor of the strategy of government regulation that, on their face, seem plausible but that I urge this committee to give a closer analysis than they have received so far.

1. Need for government-established uniform price controls: This case is grounded on the assertion that costs eliminated from government health care budgets, through such programs as mandatory cost controls and DRGs, are simply shifted by providers to other payors, such as private insurance, private patients, and outpatient clinics.

While this shifting clearly can and does occur, it may be aggravated by large-volume purchasing, be it public or private. Such shifting is quite likely to diminish as the cost-containment efforts of the private sector take hold. If, for example, preferred provider organizations and HMOs are successful in generating more efficient utilization and more favorable prices for their services, they will be able to sign up private insurers to use their services, just as they are doing with business firms. Their success in containing costs will allow private insurers to profitably write plans that the uninsured part of the population can afford. Thus, while cost-shifting can occur in the short run, there will be no need for it in the long run. It may be minimized in the long run through the competitive forces already at work. Of course, to the extent that any of us, through tax revenues or private health insurance payments, absorb the health costs of the needy and indigent, we are engaged in what I believe is a socially acceptable activity -- if the care is provided efficiently.

2. Private health initiatives are not self-sustaining and, therefore, need the threat of more government regulation: It has been argued that private sector efforts were begun in response to the threat of government regulation and will slow down if the regulatory approach is abandoned. The record shows that the acceleration of the private sector approach was in response to the increased costs of insurance premiums, health benefit packages, and other programs. But even if the private sector did need the presence of government regulatory programs to spur it into operation, there are enough such programs on the books right now to serve this purpose.

I know that every member of Congress is concerned about the costs of financing federal health care programs, especially in Medicare and Medicaid. If this spending can be contained without sacrificing the health needs of your constituents, you want to do so. In our opinion, the goal you seek will be achieved much more fairly if changes are allowed to take place in the same way the system has evolved until now. Enlightened self-interest on the part of providers, insurers, employers, and employees is the key to dealing with increased health care costs. If there are going to be changes

in health care delivery, they must be acceptable within companies and within the communities where employees work and live. This is what health care coalitions are working so hard to achieve, all over the country.

In spite of its problems, the American system of health care is the best in the world and far better than any system government alone could devise or manage. Health care needs vary from community to community. The local approach to cost management is by far the most sensible.

So, I hope that you will give us a chance to show that the private sector can do the job. Let us give patients a chance to choose and providers a chance to compete. We are confident that the massive initiatives now under way will result in the kind of care, at the kind of price, that is reasonable and equitable to all, in each community.

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Senator QUAYLE. Thank you very much.
Mr. Joseph, please proceed.

STATEMENT OF JEFFREY H. JOSEPH, VICE PRESIDENT FOR DOMESTIC POLICY, U.S. CHAMBER OF COMMERCE

Mr. JOSEPH. Thank you, Mr. Chairman.

Contrary to what our printed statement says, I am Jeff Joseph, testifying for the chamber of commerce. Our previously scheduled witness was delayed. Accompanying me is Erik Oxfeld who staffs our health-care committee.

It is important to point out that the chamber is a federation of business institutions, 3,000 State, local, and regional chambers, 1,400 trade and professional associations, and 200,000 companies, most of them small businesses. I might add, based on your opening remarks, that a number of local and State chambers are now making health-care insurance available to their small-business members, giving them the advantage of groups plans.

The chamber as a whole, the U.S. Chamber, has long supported a quality health-care system that is cost effective. Our board has been looking at this since the late 1960's. In the mid-1970's, we came up with our health-action program, a series of monographs which we believe were very instrumental in the creation of the 150 coalitions that exist at the local level, composed mainly of local benefit managers from local firms joined by physicians, hospital, and insurance organizations and, in some instances, labor people, government, and other groups. They all share a common purpose: to seek ways to help purchasers of health-care services to improve health care and contain costs voluntarily. I believe, Senator Quayle, there are at least a half a dozen in your State.

All these organizations have been formed and are operating without Government intervention or funding. We have also established here in Washington at the U.S. Chamber a clearinghouse on business coalitions for health action. It is designed to serve as an exchange groups for all these groups. We put out a monthly newsletter. We hold meetings. We put out special publications, the most recent of which was on health promotion coalitions, a catalog of health education and wellness programs being implemented by about half of the coalitions.

The argument is made, however, that health-care costs do not respond to normal market constraints. However, the rising pricetag has provided strong motivation for coalitions and individual employers to bring costs under control. The tools presently in use include incentives for employees to demand cost-effective services. We cite cafeteria plans and flexible spending accounts which, ironically, the IRS is trying to close down.

A second approach involves the use of alternative-delivery systems, such as HMO's and PPO's. Yet another technique is reduce demand by improving worker health. In addition, employers are taking steps to educate their own employees as well as intermediaries and health providers concerning the need to control rising costs. Employers are also using improved management techniques to institute cost-saving efficiencies, including scrutiny of claims for

noncovered charges, preadmission testing, second opinions, ambulatory surgery, and other basic reviews.

While it is too soon to know exactly what the overall impact has been, employers who are actively pursuing cost control have been able to slow the growth of their expenses and realize a bonus of reduced absenteeism, higher productivity, and decreased incidence of disability.

All this activity underscores the need for the private sector to work together to find ways of containing rising health-care costs without resorting to governmental intervention, including price controls or legislation that mandates benefits or limits such benefits through changes in the Tax Code. The record of Federal involvement in health-care systems is mixed. On the one hand, health insurance is so widely available, mainly because Federal laws provide favorable tax treatment. On the other hand, direct Federal involvement has been less successful. For example, in medicare and medicaid programs, politics, rather than good health-care policy or principles of economics, can be a major factor in decisionmaking. Furthermore, the Federal Government drive up employer costs by shifting expenses from Federal programs to private plans, both directly and indirectly, and examples are cited in our written statement.

Because employers are rising to the cost-containment challenge, and because the record of Federal intervention is not particularly encouraging, we remain convinced that market forces should be the principal force controlling supply and demand for health-care services. Our health-care committee is now exploring whether there are limited Government initiatives that would be acceptable, for example, with respect to assuring useful data for evaluating health-care choices or establishing reasonable contraints on medical malpractice costs.

In conclusion, we believe competition exists only when buyers and sellers are free to negotiate for products and services. We believe we need a climate in which the private action is encouraged. This does not require any legislation, but merely the support of the private and public sectors to work together to find voluntary methods of constraining costs through such coalition approaches as I have described.

Finally, the chamber recognizes the need to reduce the growth rate of spending on Federal programs generally and that, in some instances, health costs will be shifted to employers. In accepting this resonsibility, we urge the Government not to undercut employers' ability to absorb these costs by changes in tax laws.

Thank you.

[The prepared statement of Mr. Joseph follows:]

CHAMBER OF COMMERCE
OF THE
UNITED STATES OF AMERICA

ALBERT D. BOURLAND
VICE PRESIDENT
CONGRESSIONAL AND POLITICAL AFFAIRS

June 22, 1984

1615 H STREET, N.W.
WASHINGTON, D.C. 20062
202/463-5600

RECEIVED JUN 29 1984
ASI

The Honorable Orrin G. Hatch
Chairman
Senate Labor and Human Resources
Committee
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am enclosing a copy of our June 21 statement on health care cost containment before the Senate Labor and Human Resources Committee, for inclusion in the hearing record. Please substitute this copy for the one previously supplied to the Committee, which contains the name of a witness who had to cancel his planned appearance after the statement was printed.

Thank you for your cooperation.

Sincerely,

Albert D. Bourland

Enclosure

STATEMENT
on
HEALTH CARE COST CONTAINMENT
before the
SENATE LABOR AND HUMAN RESOURCES COMMITTEE
for the
CHAMBER OF COMMERCE OF THE UNITED STATES
by
Jeffrey H. Joseph
June 21, 1984

My name is Jeffrey H. Joseph. I am Vice President for Domestic Policy for the U.S. Chamber of Commerce. I am accompanied by Eric J. Oxfeld, the Chamber's Manager of Health Care and Employee Benefits.

We are pleased to express our views on health care cost containment. This subject has become quite popular, and this committee is to be commended for providing a forum for discussion, especially for those most involved -- American employers.

The U.S. Chamber is deeply concerned about providing a quality health care system that also is cost-effective. We have been a leader in seeking to control health costs through our Health Action program and the Clearinghouse of Business Coalitions. Substantial voluntary efforts to instill more competition in health care are under way and are beginning to show positive results. Government regulation of prices and wages, however, has not proven an effective means of reducing costs.

Problem: Rising Health Costs

Health care costs continue to soar and strain the public's ability to finance these services. An estimated $350 billion was spent on health care last year, 58 percent of which was paid by

private sources; the other 42 percent was paid by the federal government.

Expenditures for Medicare are doubling every five years, and without new sources of revenues or reduction in services, this program will be bankrupt by the early 1990's. The Medicaid program poses equally stiff challenges for the states. Employers also search for answers to their rising costs, which have nearly tripled since 1975.

Business is the largest private purchaser of health care in the country. Employers pay about $80 billion in group health premiums, and perhaps an equal amount on other health related items, such as taxes for Medicare, paid sick leave, compliance with health and safety regulations, and workers' compensation insurance. Eighty percent of all group health insurance is bought through the work place, with employers paying about 75 percent of the cost.

The Causes of the Problem

There are many factors contributing to the soaring costs of health care, including:

- better and more costly health services (e.g., innovations in medical equipment and technology);
- malpractice insurance and defensive medicine practices, conservatively estimated to be about 6 percent of the total health care bill;
- inefficiency in the delivery of services, for which little or no economic sanctions exist;
- overutilization of available services as a result of demand stimulated by Medicare, Medicaid and the incentives inherent in fee-for-service, cost reimbursement, and third party insurance which typifies the health care system; and

- Americans' belief that good health is of great importance and their willingness to devote substantial resources to health treatment.

Chamber Position on Increased Competition in Health Care

The U.S. Chamber supports the development of a more cost-effective, competitive health care system that will enable all Americans to have access to quality care at affordable prices. More competition should have the same effect on health care that it has on the rest of the economy. It should provide choices to buyers, stimulate innovation by sellers, and ultimately result in more stabilized costs for both. Market forces are the best way to achieve these objectives. However, government regulation -- despite good intentions -- will not, and it may be counterproductive to the goal of an improved health care system.

Voluntary Action

In opposing government regulation of prices and wages, the Chamber remains steadfast in its support for improving the health care system, including finding ways to contain its rising costs.

This interest was demonstrated over a decade ago when our Economic Policy Department highlighted various trends and developments in a white paper. This paper underscored the need for the private sector to monitor and evaluate the effectiveness of public health programs such as Medicare and Medicaid, as well as private health insurance plans. The report was followed in the early 1970s by creation of the Chamber's Health Care Committee, which recommends policy on health care issues to our Board of Directors.

In 1976, the President's Council on Wage and Price Stability issued a perceptive and prophetic document entitled "The Complex Puzzle of Rising Health Care Costs: Can the Private Sector Fit It Together?" The book concluded that "cost control incentives proposed by the private sector promise to be more effective than those imposed by the multitude of government agencies [because] the private sector is motivated by economic incentives which the government will simply never share. [They are] the key ingredients in bringing about much needed change in the system."

About the same time, the Chamber decided to conduct its own investigation into the reasons for rising health care costs and to determine how they could be contained. Accordingly, we undertook a comprehensive study of the issue that eventually resulted in our widely acclaimed Health Action program. The basis for this program is a series of action-oriented monographs explaining in what ways business is involved in health care and how it can contribute to improving health while containing cost.

The Chamber's Health Action program was implemented in early 1979. Since that time, over 150 local business coalitions for health action have been formed, many of which are sponsored by local or state chambers of commerce. These coalitions are composed of employee benefit managers from local firms, who in many cases are joined by representatives of physicians, hospital and insurance organizations, and/or to a lesser extent, labor, government, and other health-related groups. All share a common purpose: to seek ways of helping purchasers of health care services improve health care and contain costs voluntarily.

It must be noted that all of these organizations have been formed and are operating without governmental intervention or funding. They are the epitome of the principle that local problems

respond best to locally developed solutions, because the developers have a major vested interest in these solutions.

Coalition Clearinghouse

Having helped to create many of these business/health coalitions, the Chamber also established a central repository of information for and about these groups. Therefore, in early 1982 when there were no more than 25 coalitions, we established the Clearinghouse on Business Coalitions for Health Action.

The Clearinghouse helps coalitions exchange their successes and failures with other groups or communities that are seeking to develop similar organizations. Part of this activity helps them redesign health care benefits, become involved in health care alternatives, establish employer health education programs, and become more effective health planners, both on health planning agencies and hospital boards.

The various services and products of the Clearinghouse have played a role in their growth. For example, it issues a monthly newsletter, Coalition Report, free to all coalitions and another 10,000 readers, all of whom are involved or interested in the purchase of health services.

The Clearinghouse also issues special publications dealing with cost containment topics. The most recent of these is Health Promotion and Coalitions, a catalogue of health education and wellness programs being implemented by about half of the coalitions. We also issue an annual directory of coalitions.

Among the Clearinghouse's services are a mail and telephone answering service, annual and periodic meetings emphasizing new ideas

for cost containment, and technical assistance provided either directly by the Clearinghouse or through referrals to experts in the field.

All of this activity underscores the need for the private sector to work together to find ways of containing rising health care costs, without resorting to governmental intervention, including price controls or legislation that mandates benefits or limits such benefits through changes in the tax code.

Action by Private Sector to Control Cost

The argument is made that health care costs do not respond to normal market constraints. However, the ever-rising price tag for worker health care plans, in fact, has provided strong motivation for individual employers to bring costs under control by all available means. Among the tools presently in use [1/] are the following:

- Incentives for Employees to Demand Cost-Effective Services -- Workers whose insurance plans require minimal employee outlays are relatively insulated from the cost of health services employee outlays and may have little direct incentive to demand cost-effective health care. Some providers may also take advantage of insurance arrangements if they know that a third party is paying for all or nearly all of the tab. Employers are attempting to combat

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1/ A good description of these practices, and the extent of their utilization, is contained in "Company Practices in Health Care Management," a 1984 survey by Hewitt Associates.

the attitude that "somebody else is paying" by increasing deductibles and employee copayments and contributions. A June 1984 study by the American Society of Internal Medicine, "Cost Sharing: A White Paper," concludes that "significant savings would result from improved patient cost sharing." One means of overcoming employee resistance to cost sharing is the use of cafeteria plans and flexible spending accounts (FSA's), which reward individuals who use health services frugally. This can be an effective means of steadying costs by reducing demand. Ironically, the IRS has taken the position that FSAs, which may involve a mix of taxable and nontaxable payments, are an effort to increase the amount of tax-free benefits. The Chamber is working to persuade Congress to override the IRS effort to curb FSA's.

- Alternative Delivery Systems — A second approach involves use of alternative delivery systems, such as health maintenance organizations (HMO's) and, more recently, preferred provider organizations (PPO's). A recent Rand Corporation study of HMO's reported 25 percent lower costs than traditional fee-for-service arrangements, for instance. These plans can assure that services are provided by cost-conscious practitioners, and that unnecessary services are avoided. At the same time, many of these plans provide greater attention to preventive, rather than reactive, treatment.

- Wellness Programs — Yet another technique is to reduce demand by improving worker health. Existing sick leave benefits may "reward" sickness.

Accordingly, many employers are attempting to reverse the emphasis by rewarding wellness. In addition, on-site physical fitness facilities and employee assistance plans are increasingly used to help employees stay healthy.

- Awareness Campaigns -- As long as health care is regarded as a "free" fringe benefit, its economic effect may be disguised. Employers are taking steps to educate their own employees, as well as intermediaries and health care providers, that there is indeed a price to pay. Higher payroll costs to provide health insurance can have a substantial, direct effect on employment. For example, as demand grows for their products and services, employers may increase production by increasing overtime rather than the size of their workforce. Furthermore, funds unnecessarily spent on benefits could be used more productively as capital or paid to workers as higher wages. Of course, to the extent that health insurance costs are needlessly high, employers, especially small businesses, will be forced to reduce -- or drop -- coverage, and fewer individuals will have health care protection. The success of these efforts is reflected in collectively bargained changes in health benefits and the establishment of labor-management teams to slow the rise of company health care costs.

- Better Management -- Employers are also using improved management techniques to institute cost-saving efficiencies. These include scrutiny of

claims for non-covered charges, preadmission testing, second opinions, ambulatory surgery, precertification, coordination of benefits, fee negotiations, and concurrent review. The Health Research Institute reports in its Biennial Cost Containment Survey that these techniques can reduce costs by as much as 30 percent.

The wide variety of voluntary cost control methods means that employers can tailor their efforts to local conditions. While it is too soon to know what the overall impact has been, initial results from steps taken so far have been favorable. Employers who are actively pursuing cost control have been able to slow considerably the growth of their expenses -- and realize a bonus of reduced absenteeism, higher productivity, and decreased incidence of disability.

Counterproductive Government Intervention

The proper role of the federal government in the health care system is to establish broad, flexible and voluntary goals for national health care, consistent with reasonable health, social, and economic goals for the nation. In general, federal programs are appropriate only when the private sector or state government cannot satisfy an important health care need.

The best example of a successful governmental role in the health care system is the basic income tax incentive for employers to offer health insurance to their workers. Health insurance is so widely available mainly because the tax laws allow employers to deduct health insurance premiums as a business expense and allow employees to receive such benefits as tax-free compensation. In addition, the earnings of health benefit trust funds are also exempt from taxes, which has encouraged employers to expand health care provided to retirees. Finally, an individual's medical costs (including health

insurance premiums) exceeding 5 percent of adjusted gross income may be deducted.

On the other hand, more direct federal involvement has been much less successful. It is generally accepted that the government can play a useful role in providing health care for the aged and the poor, groups that the market may not serve well. However, even the Medicare and Medicaid programs illustrate the disadvantages of government action. In these programs, politics, rather than good health care policy or principles of economics, can be a major factor in decisionmaking -- witness the continuing congressional efforts to redefine service delivery areas for hospitals as "urban" rather than "rural" to qualify for a higher level of reimbursement.

Another example of a proposed federal intervention that would be counterproductive is the health care tax cap, which would, among other things, discriminate against workers in high cost-of-living localities and those who participate in HMO's or whose employers otherwise provide broad, cost-effective preventive health services.

Similarly, recent proposals for federal programs to provide health care for the unemployed would have a deleterious effect on the health care system. Mandatory employee coverage of former employees would force many employers either to reduce or drop benefits for remaining employees, or lay off additional workers.

Finally, the federal government has driven up employer costs by shifting expenses from federal programs to private plans, both directly and indirectly. Direct cost shifting occurred in 1977, when Medicare discontinued reimbursement to hospitals for depreciation and bad debt expenses. The 1982 Tax Equity and Fiscal Responsibility Act required employers to be the primary insurer of workers age 65 or over (formerly Medicare was primary). The tax bill now in conference, H.R. 4170, would shift additional costs to employers by postponing Medicare eligibility by up to a month and by making Medicare the secondary payor for spouses of employees. These two provisions alone would save

Medicare over $1.7 billion and raise employer costs accordingly. The potential exists for substantial indirect cost shifting in Medicare and Medicaid, by capping prices for reimbursed health services. For example, the Diagnostic Related Group (DRG) approach to fixing prices does not allow for malpractice expenses, which therefore are passed on to private consumers.

To reduce cost shifting among payers and encourage cost containment competition among providers, we support prospective pricing in payment systems for health care. For this reason, we were pleased that the committee report accompanying P.L. 98-21, the Social Security Act Amendments of 1983 -- which implemented Medicare's DRG-based prospective payment plan for hospitals in October 1983 -- also mentioned the need to review the program for its effect on cost shifting. To this end, the act created the Prospective Payment Assessment Commission (PROPAC), which has been charged with monitoring and evaluating the new Medicare payment system. Hopefully, PROPAC will help to eliminate or at least reduce cost shifting from public to private health care programs, since this phenomenon is costing employers an estimated $10 billion per year.

Because employers have risen to the challenge with alacrity, and because the record of federal intervention is not encouraging, we remain convinced that market forces should be the principal force controlling supply and demand for health care services. Our Health Care Committee is now exploring whether there are limited federal initiatives that may be desirable, for example with respect to assuring useful data for evaluating health care choices, or establishing reasonable constraints on medical malpractice costs.

Conclusion

Competition exists only when buyers and sellers are free to negotiate for products and services. Better purchaser and consumer

awareness of health services and their costs are helping improve competition in health care. Federal regulation of prices and wages has not been successful before, and there is little reason to believe that it will work with the health care system. Such legislation also could increase, rather than contain, costs, as well as have the overall effect of reducing the number of Americans protected from health care costs.

A better alternative is to create a climate in which private action is encouraged. This does not require any legislation but merely the support of the private and public sectors to work together to find voluntary methods of containing costs, such as through the coalition approach. The U.S. Chamber and many other segments of the private sector are committed to reducing costs by helping this kind of competition thrive.

Finally, the Chamber recognizes the need to cut spending on federal programs generally and that in some instances health costs will be shifted to employers. In accepting this responsibility, we urge the government not to undercut employers' ability to absorb these costs by changes in tax laws.

Senator QUAYLE. Thank you very much.
Mr. Greenwald.

STATEMENT OF GERALD GREENWALD, VICE CHAIRMAN OF THE BOARD, CHRYSLER CORP., DETROIT, MI

Mr. GREENWALD. Thank you and good afternoon.

I am Gerald Greenwald, vice chairman of the board of Chrysler Corp.

I would like to commend the committee for holding these hearings on health-care reform. I also would like to commend the sponsors of the Kennedy-Gephardt legislation for their extensive efforts in seeking to address this very critical issue. These hearings couldn't be more timely. More than any other cost of doing business in the United States, health-care costs are escalating to the point that they are severly threatening American industry's ability to compete with foreign companies and with foreign countries, a concern that, in our view, our entire Nation should be focusing on.

In 1984, Chrysler's health-insurance premiums will exceed $400 million. That is $1.1 million per day, and it means that Chrysler's biggest supplier is not a steel company, or a tire company, or a glass company; it is Blue Cross/Blue Shield.

This year, Chrysler's total health-care bill will exceed $550 per car that we sell or about 10 percent of the price we charge for an Omni or a Horizon. Said a little differently, Chrysler must sell 70,000 cars and trucks just to pay its health-care bills, and that is before we pay any employee wage increases, or invest in modernizing our plants, or fund new product programs to remain competitive.

If you are looking for the single biggest disadvantage outside of differentials and currency manipulation, American car companies face versus the Japanese, don't look to wage rates; look to health care. We know, for example, our own partner, Chrysler's Japanese partner, Mitsubishi Motors, spends about $815 per year for each active employee's health-care costs, while Chrysler spends per active employee $5,700.

I believe we have all contributed mightily to the results: unions which demanded more health-care coverage as a tax free fringe benefit for their members; busnesses like Chrysler, who, in history, signed the dotted line on these contracts; the Government, which superimposed medicare and medicaid right on top of the existing cost-based fee-for-service system; doctors and hospitals which are cashing in on the repeal of the law of supply and demand in health care; and finally, lawyers, and judges, and juries who have fed the monster with malpractice litigation that established unpredictable and unrealistic standards of negligence while whopping judgments against doctors and hospitals who failed to run some obscure test seem to be applied.

As an indication of this, we ran some statistics and found that the average Chrysler employee received five blood tests last year. I didn't receive any; that means somebody got poked 10 times.

It took all these parties to get us into this health-care mess, and it is going to take the cooperation of all these parties to get us out.

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I would say that Chrysler, for one, has taken several positive steps with the cooperation of the UAW to make some progress toward cutting health-care costs while, at the same time, actually improving health care. Together, these programs have saved $20 million off the $400 plus million a year which is certainly a step in the right directly but still hardly puts a dent in the huge health-care cost that we face.

So, while Chrysler is trying to do everything it can to control health-care cost by eliminating waste and inefficiency, we must recognize that Chrysler and American business in general cannot control health-care costs alone, especially if we are going to be able to compete for our markets against the Japanese that are competing with us.

Unfortunately, the problem has been compounded by the cost shifts resulting from medicare and medicaid efforts to reduce expenditures. Even the new medicare prospective-payment system which is a step in the right direction permits costs to be shifted by hospitals to the private sector. I have submitted some specific examples in my written statement and I won't dwell on them at the moment.

Future medicare reforms would penalize business even more harshly. For example, the proposal by the Advisory Council on Social Security to delay medicare eligibility from age 65 to 67 would cost Chrysler alone about $100 million over the next 5 years. Over the next 10 years, the delay would cost all American businesses and citizens an astounding $75 billion.

In the long run, the answer is to stop passing the buck, stop playing the cost control shell game, and start instituting some really systemwide reforms. To that end, Chrysler would recommend that the Congress this year enact legislation to establish a national commission on health-care reform similar to the National Commission on Social Security Reform. The commission's charge should be to develop a national health policy and its membership should include representatives of all interested parties, business and labor, senior citizens, lawyers, physicians, hospitals, among others. The commission can provide a forum to develop a comprehensive strategy to reduce costs without reducing care.

I might add that achieving this goal will take the wholehearted cooperation of American labor, especially the UAW in its critical trend-setting negotiations with General Motors and Ford this summer. As an illustration, the "Big Three" alone spend $3.2 billion in health care in 1 year. That is more than the total expenditures of 18 of our States.

I would like to simply close by observing that working together with the unions to cut out-of-control health-care costs is one of the key elements of Chrysler's proposal to revitalize the American auto industry, a proposal which includes a number of elements including freezing small car prices against foreign competition, dealing with freezing of foreign component outsourcing, and dealing with a whole host of other matters including executive bonuses.

We stand ready to do our part to make American industry more competitive including in the area of health care, but we can't do the job alone. We need the help of the Government, and that help should begin with the immediate formation of a national commis-

sion on health care reform. I urge this Congress to create such a commission and require the commission to make its report to the administration, the Congress, and the American people within one year so that the next Congress can act quickly on this most important issue for our Nation.

Thank you very much.

[The prepared statment of Mr. Greenwald and responses to questions submitted by Senators Grassley and Hatch follows:]

Statement by Gerald Greenwald, Vice Chairman of the Board, Chrysler Corporation, on "Competing Approaches to Health Care Cost Control," before the U.S. Senate Committee on Labor and Human Resources, Washington, D.C., June 21, 1984

Thank you, and good morning. I am Gerald Greenwald, Vice Chairman of the Board of the Chrysler Corporation.

I commend this Committee for holding these hearings on health care reform. I also commend the sponsors of the Kennedy-Gephardt legislation for their extensive efforts in seeking to address this very critical issue. These hearings couldn't be more timely. More than any other cost of doing business, health care costs are escalating to the point that they are severely threatening American industry's ability to compete with foreign companies and countries -- a concern that our entire nation should share.

At the outset, I should say that while I applaud the efforts of those seeking to reform Medicare, to develop more competitive health care delivery systems, and to generally improve the health care system we presently have, I believe Congress must take a more comprehensive, system-wide approach as it addresses the health care cost issue. Only by taking such an approach will we be able to formulate a coordinated effort to eliminate the waste, inefficiency, and inequities inherent in the delivery of health care in America, and provide quality health care for all citizens.

Let me provide the Committee with a little history from Chrysler's perspective to illustrate the severity of the problem for American business and the need for a comprehensive solution.

Chrysler first began to provide its employees with partially paid, company-sponsored health care benefits back in 1950. At that time, the cost of the program was reasonable. However, over the years, as that first step broadened to first-dollar coverage, as collective bargaining with the UAW expanded the list of covered services to include everything from eye care to psychiatric counseling, and as the advent of Medicare and Medicaid helped feed the illusion that health care paid for by some third party (either the government or business) is free, our costs began to escalate at double-digit rates.

In 1984, Chrysler's health insurance premiums will exceed $400 million. That's $1.1 million per day, and it means that Chrysler's biggest dollar supplier is not National Steel or Goodyear Tire or Pittsburgh Glass, but Blue Cross/Blue Shield.

This year, Chrysler's total health care bill (which includes our Medicare payroll tax and a portion of our suppliers' health insurance premiums) will exceed $550 for each car we sell -- almost a tenth of the sticker price of Dodge Omni or Plymouth Horizon. That's down somewhat from $600 a car last year -- not because inflation in health care costs has abated, but because we're selling more cars. This year -- and this is shocking to me --Chrysler must sell about 70,000 cars and trucks just to pay for its health care bills. That's <u>before</u> we can pay employee wage increases, invest in modernizing our plants, fund new product programs, or do anything else.

And if you're looking for the single biggest disadvantage (outside of tax differentials and currency rates) that American car companies face versus the Japanese, don't look to wage rates;

look to health care. We know, for example, that Chrysler's Japanese partner, Mitsubishi Motors Corporation, spends only about $815 a year for each active employee's health care costs, while each Mitsubishi employee pays approximately $374. Unlike Chrysler, Mitsubishi has no direct cost for retirees or their surviving spouses, thanks to Japan's national health coverage. Chrysler's comparable cost per active employee is $5,700 -- 400 percent higher.

Certainly, these types of horrendous costs are not restricted just to Chrysler, nor to the auto industry in particular. Health care costs are running rampant throughout American industry. Within our present national structure, we've created a Frankenstein health care payment system.

And, I believe, we've all contributed mightily to the effort: unions, which demanded more health care coverage as a tax-free fringe benefit for their members; businesses, which signed the dotted line in these contracts; the government, which superimposed Medicare and Medicaid right on top of the existing cost-based, fee-for-service system; doctors and hospitals, which are cashing in on the repeal of the law of supply and demand in health care; and finally, lawyers, judges, and juries who have fed the monster with malpractice litigation that established unpredictable and unrealistic standards of negligence and whopping judgments against doctors and hospitals who failed to run one test or another.

It took all these parties to get us into this health care mess, and it's going to take the cooperation of all these parties to get us out.

I will say that Chrysler, for one, has taken several positive steps, most with the total cooperation of the UAW, to make some progress toward cutting health care costs, while at the same time actually improving care.

Some of these steps include setting up a screening program for foot surgery, which cut unnecessary utilization 60 percent and saves over one million dollars a year; beginning a generic drug program, which saves a quarter million dollars a year; mandating second medical opinions before certain elective surgeries, which has saved another million dollars a year while cutting down on unnecessary operations and hospital stays; instituting programs to encourage outpatient surgery, which saves two million dollars a year; and offering financial incentives to encourage enrollment in HMOs.

Together, these programs have saved Chrysler nearly $20 million in two years -- which is certainly a step in the right direction, but still hardly a dent in the huge health care costs we face.

So while Chrysler is trying to do everything it can to control health care costs by eliminating waste and inefficiency, we must recognize that Chrysler and American business in general cannot control health care costs alone -- especially not if we're going to be competitive with countries like Japan.

Unfortunately, the problem has been compounded by the cost shifts resulting from Medicare and Medicaid efforts to reduce expenditures. Even the new Medicare prospective payment system, which is a step in the right direction, permits costs to be shifted by hospitals to the private sector. These policies are

no more than a shell game in which the government may have the illusion that it's making progress on controlling health care costs, but when in fact, it's just passing the pea to private industry in what amounts to a "hidden tax" for business.

Here are a couple of examples of how these sleight-of-hand tricks don't really reduce health care costs, but merely pass them along to business:

* First, in 1965, a Medicare beneficiary had to pay the first $40 of a hospital stay; today, under already-enacted Medicare reform, that deductible has been raised to $356. Similarly, the daily co-payment for long-term hospital stays has been increased from $10 to $89 (for the 60th to 90th day of an admission). Chrysler, like many other companies, absorbs 100 percent of these increases. Just the latest increase in the hospital deductible alone costs Chrysler $1 million a year.

* Second, this year, hospitals in Michigan will shift $2 million in bad debts to Chrysler, although Chrysler had nothing to do with the debts being bad in the first place. But Chrysler must pay up because Medicare and Medicaid won't allow cost-shifting to them. And in the meantime, nothing is being done to solve the question of the "coverage gap" which caused the bad debts in the first place.

* And third, another so-called Medicare "reform," the Tax Equity and Fiscal Responsibility Act of 1982, requires that employers provide primary coverage for employees and their spouses over age 65, coverage that Medicare

used to provide. The cost to Chrysler was $1.4 million in 1983, and will increase annually. The cost to all U.S. businesses is over $1.5 billion annually.

Future Medicare-only reforms could penalize business even more harshly. For example, the proposal by the Advisory Council on Social Security to delay Medicare eligibility from age 65 to age 67 would cost Chrysler about $100 million over the next five years. Over the next ten years, the delay would cost all American businesses and citizens an astounding $75 billion. Even worse, since such cost-shifting would not eliminate a single dollar of waste or inefficiency in our health care system, it would accelerate our head-long rush toward health care rationing in this country, such as we see already in Great Britian.

In the long run, the answer is to stop passing the buck, stop playing the cost-control shell game, and start instituting some real, system-wide reforms. To that end, Chrysler recommends that the Congress this year enact legislation to establish a National Commission on Health Care Reform, similar to the National Commission on Social Security Reform.

The Commission's charge should be to develop a national health policy, and its membership should include representatives of all interested parties -- federal, state, and local governments; business and labor; senior citizens and junior citizens; lawyers, physicians, hospitals, and health insurers. The Commission can provide a forum to develop a comprehensive strategy to reduce costs without reducing care.

I might add that achieving this goal will take the wholehearted cooperation of the American labor movement, and

especially of the UAW in its critical, trend-setting negotiations with General Motors and Ford this summer.

The Big Three auto companies spent a total of $3.2 billion for health care last year, which exceeds the total expenditures of 18 states and the collected taxes of an estimated 31 states. That's clout. If the Big Three -- GM, Ford, and then Chrysler next year -- can negotiate trend-setting health care benefit plans with the UAW which are designed to spur competition while still enhancing health care quality, they can do more to change America's health care delivery system than any other combination of big business and big labor in our nation.

Implicit in this new kind of health care delivery system should be, I might add, the reclaiming by government, business, and the individual of our long-ago surrendered right not to deal with certain health care sellers. Once we again get to exercise this right, I think we'll see the end of the "supply-side" sellers' markets -- where the real buyer never sees the bill.

And let me add that working together with the union to cut out-of-control health care costs is one of the key elements of Chrysler's proposal to revitalize the American auto industry, a proposal which includes freezing small-car prices, freezing foreign component outsourcing, and limiting executive bonuses.

We stand ready to do our part to make American industry more competitive, including in the area of health care, but we can't do the total job alone. We need the help of the government, and that help should begin with the immediate formation of a National Commission on Health Care Reform.

I urge this Congress to create such a Commission and require it to make its report to the Administration, the Congress, and the American people within one year, so that the next Congress can act quickly on this most important issue for our nation.

Thank you very much.

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ANSWERS TO SEN. GRASSLEY'S QUESTIONS

1. Question: You discussed "cost" or "charge-shifting" at some length in your statement. Now, when the prospective payment system for hospitals was introduced, its proponents argued that hospitals would become more efficient in the face of the reimbursement limits instituted by the new system. Let me just be sure exactly what your position is on this. Is it your position that efficiencies do not result from this new program, but that hospitals simply shift costs to non-covered payers?

   Answer: We believe Medicare's prospective payment system has clearly prompted positive action by many hospitals to deliver services in a more cost-effective manner. However, this does not mean the payment in all cases is adequate nor does it mean all hospitals have been similarly motivated. In either situation, cost shifting is possible.

2. Question: You recommended in your statement that a national commission on health care reform be created to develop a national health care policy. Creation of this commission does not necessarily imply anything about specific substantive approaches to reform of the system. Does your organization tend to prefer competitive, market-oriented approaches, or a public utility, regulation approach?

   Answer: We definitely see a major role for competing, alternative health care delivery systems in the battle to manage health care costs. We also, however, foresee a need for government, both federal and state, to involve themselves in the process. Government plays such a major role today in health care, in terms of financing care, research, hospital construction, etc., that we believe it is not reasonable to expect true health care cost containment is possible without government participation.

ANSWERS TO SEN. HATCH'S QUESTIONS

1. Question: What are the benefits for industry and employers in creating a competitive environment among health care providers?

   Answer: For the same reasons industry seeks to control the cost of purchased goods and services by insisting on competitive bids, it cannot afford to leave costs the magnitude of those generated by health services to the whims of a seller-dominated, non-price-competitive market. Accordingly, the more health care "sellers" are forced to compete, the better it will be for health care "buyers" like industry and employers, and in turn, for consumers.

2. Question: How are employers responding to increasing insurance premiums and the pressure to expand employee health coverage?

   Answer: Basically in two ways: first, cutting back on employee benefit programs, generally through introducing or increasing employee cost sharing; second, by introducing benefit plan design changes intended to prompt more efficient benefit utilization, such as second opinion programs. Some employers are doing both.

3. Question: What impact would a tax cap on employer contributions have on employee health plans?

   Answer: We believe a tax cap would prompt the offering of alternative, lower-cost health care plans and would enhance their acceptability by employees.

Senator QUAYLE. Thank you very much.
Ms. OWLEY.

STATEMENT OF CANDICE OWLEY, VICE PRESIDENT, AMERICAN FEDERATION OF TEACHERS, MILWAUKEE, WI

Ms. OWLEY. Thank you, Mr. Chairman.

I would like to begin by telling you what an honor and pleasure it is for me to be here this morning. I would add that this is the first Senate hearing I have ever seen even, so bear with me and I will do my best.

Mr. Chairman and members of the committee, my name is Candice Owley, and I am the national vice president of the American Federation of Teachers. I chair the AFT's Federation of Nurses and Health Professionals Steering Committee. I am a registered nurse by profession and my home is in Milwaukee, WI. On behalf of AFT's 600,000 members, and also I might add, on behalf of the AFL-CIO, I thank you for this opportunity to testify this morning or this afternoon in support of the Medicare Solvency and Health Care Financing Reform Act of 1984, the Kennedy-Gephardt bill.

Cost containment that assures high quality, affordable, and accessible health care, while protecting the solvency of medicare is a vital concern of workers and retirees throughout the country.

Over the past 20 years, national annual expenditures for health care have incrased more than tenfold. We currently spend in the neighborhood of $1 billion a day on health care, and by the end of the decade, this Nation's medical expenditures will have risen to $2.7 billion a day.

But while the United States spends substantially more per capita on health care goods and services than other countries, we still lag behind nations such as Sweden, the United Kingdom, Japan, and Canada in life expectancy and in the reduction of infant mortality. Costs continue to rise dramatically, but we are not receiving full value for the dollars we spend. Increasingly, the primary victims of soaring medical costs have become working people, families on fixed incomes, nonsupervisory health care workers, retirees, and the unemployed. All too often, these victims of skyrocketing health cost inflation become the targets of cost shifting rather than the beneficiaries of cost containment. In many instances, cost containment has become a euphemism for higher out of pocket expenditures, lower quality of care, reductions in numbers of nurses and other necessary hospital personnel, cutbacks in needed services, and curtailed access to the health care system.

Between 1973 and 1983, the cost of health insurance premiums for all State employees nationally rose by an average of nearly 390 percent. During the past 3 years, the average out of pocket deductible health care costs for these workers increased 58 percent. A recent Bureau of National Affairs survey of 221 representative employers, including educational institutions, government agencies, and private sector employers, reported an almost doubling of median health insurance costs between 1977 and 1983. Cost containment measures most frequently advanced at the bargaining table by these employers included: increased out of pocket deducti-

bles, raising employee contributions toward premiums, higher employee copayments, and limitations on certain types of coverages.

Typically, AFT members at the local level face annual health insurance premium increases approaching 30 percent. The tradeoffs with respect to wages, pensions, purchasing power, and working conditions, including sifficient personnel, equipment, and everyday supplies, are obvious. By the time the average worker reaches retirement, 20 percent of his or her annual income will go toward the payment of health care expenditures.

For nurses and other nonsupervisory health care workers, the situation is doubly perilous. Faced with the same escalating health care costs as other workers, nonsupervisory health care personnel are often the first casualties of employer efforts to trim costs and reduce services.

As a result of the Reagan administration's strategy to shift costs of medical cost inflation to consumers of care, over 490,000 low income families, many of them working poor, have lost their categorical eligibility for medicaid coverage. According to recent estimates by the Urban Institute, 19 percent of the total U.S. population has no medical insurance coverage at all.

Shifting the burden of health cost inflation to workers, retirees, low income families, the unemployed, and consumers of care is neither equitable nor, in the long run, effective.

The causes of health care cost inflation are neither overindulging consumers nor overpaid nurses and health care workers. The major reasons for the rapid escalation of health care costs in the United States include:

A fee for service delivery system that encourages proliferation of surgical procedures, unnecessary services, medication, laboratory tests, and medical interventions, while discouraging prevention and wellness programs;

Physicians whose fees continue to rise faster than inflation and whose mean annual income exceeds $99,000. Physicians, not consumers, account for 70 percent of all health care decisions;

The growth of proprietary health care chains, whose profits last year increased by more than 31 percent. Recent studies have shown that while for profit chains have reduced the numbers of licensed nurses by as much as 37 percent, they charge 24 percent more for the same services and procedures than nonprofit facilities;

And a fragmentated nonsystem of health care finance that permits and even encourages inflation, waste, and cost shifting among payers, nearly unlimited technological expansion, and excessive returns on equity.

Only a comprehensive system of cost containment, covering all providers and payers, can bring about the structural changes to assure medicare's solvency and to hold down costs over the long run.

To be sure, significant short term savings can be achieved through various competitive approaches and changes in benefit designs. Last year, the Chicago Teachers Union and the Chicago Board of Education trimmed $3.9 million from a proposed $12.9 million increase in health insurance premiums by negotiating limitations on weekend hospital admissions, mandatory second opin-

ions for elective surgery, financial incentives for ambulatory surgery, and preadmission out patient testing.

Similarly, AFT locals in Florida, New York, and elsewhere have taken the initiative in negotiating health plans that include PPO's and HMO's and other alternatives to traditional health care services. The Federation of Nurses and Health Professionals, AFT's Health Care Division, represents employees of Oregon's Kaiser Health Plan, so we know first-hand the cost saving and quality of health care advantages associated with health maintenance organizations. On the national, State, and local levels, the AFT has been actively involved in the promotion of cost containment through collective bargaining, benefit restructuring, utilization review, improved data reporting and collection, more effective and responsive insurance administration, alternative delivery programs, and responsible competitive strategies.

But while the cost savings realized through competition, benefit restructuring and improved plan administration are not inconsequential, they occur primarily at the margins and exert no permanent comprehensive control over prices.

While AFT generally supports responsible competition approaches, we are also aware of their limitations. Competition alone is insufficient to assure affordable, accessible, and high quality care over the long term.

We support the Kennedy-Gephardt bill because it offers a comprehensive, fair, and effective alternative to our current system of health care financing. Inclusion of all providers and all payers assures effective control of expenditures while preventing the unfair shifting of costs among consumers and purchaser of care. It would also assure financial help for hospitals that provide a high volume of unreimbursed and charity care.

This legislation promotes competition and individual State initiatives, but within a broader framework that assures that benefits of competitive initiatives will be sustained far into the future. The bill permits sufficient flexibility to encourage States to shape programs best suited to their individual needs.

Finally, we support this legislation because it assures the solvency of the Medicare Program without further penalizing its beneficiaries.

We support this legislation on the grounds of equity and effectiveness, and we urge that you act favorably upon it.

Thank you.

[The prepared statement of Ms. Owley follows:]

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ALBERT SHANKER
President

TESTIMONY BEFORE THE

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

ON THE ISSUE OF HEALTH CARE COST CONTAINMENT

Washington, D.C.
June 21, 1984

by

Candice Owley

National Vice President, American Federation of Teachers, AFL-CIO

Chairperson, Federation of Nurses and Health Professionals

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Mr. Chairman and Members of the Committee:

My name is Candice Owley, National Vice President of the American Federation of Teachers, AFL-CIO and Chairperson of the AFT's Federation of Nurses and Health Professionals Steering Committee. I am a registered nurse by profession, and my home is in Milwaukee, Wisconsin. On behalf of AFT's 600,000 members, I thank you for this opportunity to testify this morning in support of the Medicare Solvency and Health Care Financing Reform Act of 1984, the Kennedy-Gephardt Bill.

Cost containment that assures high quality, affordable and accessible health care, while protecting the solvency of Medicare is a vital concern of workers and retirees throughout the country.

Over the past 20 years, national annual expenditures for health care have increased more than tenfold. We currently spend in the neighborhood of $1 billion a day on health care, and by the end of the decade this nation's medical expenditures will have risen to $2.7 billion a day.

But while the United States spends substantially more per capita on health care goods and services than other countries, we still lag behind nations such as Sweden, the United Kingdom, Japan and Canada in life expectancy and in the reduction of infant mortality. 1/

Costs continue to rise dramatically, but we are not receiving full value for the dollars we spend. Increasingly, the primary victims of soaring medical costs have become working people, families on fixed incomes, non-supervisory health care workers, retirees and the

unemployed. All too often these victims of skyrocketing health cost inflation become the targets of cost shifting rather than the beneficiaries of cost containment. In many instances, "cost containment" has become a euphemism for higher out-of-pocket expenditures, lower quality of care, reductions in the number of nurses and other necessary hospital personnel, cutbacks in needed services and curtailed access to the health care system.

Between 1973-1983, the cost of health insurance premiums for all state employees nationally rose by an average of nearly 300%. During the past 3 years, the average out-of-pocket deductible health care costs for these workers increased 58%. 2/ A recent Bureau of National Affairs survey of 221 representative employers (including educational institutions, government agencies and private sector employers) reported an almost doubling of median health insurance costs between 1977-1983. "Cost containment" measures most frequently advanced at the bargaining table by these employers included: increased out-of-pocket deductibles, raising employee contributions toward premiums, higher employee co-payments, and limitations on certain types of coverage. 3/

Typically, AFT members at the local level face annual health insurance premium increases approaching 30%. The trade offs with respect to wages, pensions, purchasing power and working conditions —including sufficient personnel, equipment, and every day supplies—are obvious. By the time the average worker reaches retirement, 20%

of his or her annual income will go toward the payment of health care expenses.

For nurses and other non-supervisory health care workers, the situation is doubly perilous. Faced with the same escalating health care costs as other workers, non-supervisory health care personnel are often the first casualties of employer efforts to trim costs and reduce services. 4/

As a result of the Reagan Administration's strategy to shift the costs of medical cost inflation to consumers of care, over 490,000 low income families—many of them the working poor—have lost their categorical eligibility for Medicaid coverage. 5/ According to recent estimates by the Urban Institute, 19% of the total U.S. population has no medical insurance coverage at all.

Shifting the burden of health cost inflation to workers, retirees, low income families, the unemployed and consumers of care is neither equitable nor, in the long run, effective.

The causes of health care cost inflation are neither over-indulging consumers nor over-paid nurses and health care workers. The major reasons for the rapid escalation of health care expenditures in the United States include:

- o A fee-for-service delivery system that encourages a proliferation of surgical procedures, unnecessary services, medication, laboratory tests and medical

interventions while discouraging prevention and wellness programs.

- Physicians whose fees continue to rise faster than inflation and whose mean annual incomes exceed $99,000. Physicians, not consumers, account for 70% of all health care decisions.
- The growth of proprietary health care chains whose profits last year increased by more than 31%. 6/ Recent studies have shown that while for profit chains actually reduce their numbers of licensed nurses by as much as 37%, 7/ they charge 24% more—for the same services and procedures procedures—than non-profit facilities. 8/
- A fragmented non-system of health care finance that permits and even encourages inflation, waste, cost shifting among payers, nearly unlimited technological expansion, and excessive returns on equity.

Only a comprehensive system of cost containment, covering all providers and payers, can bring about the structural changes necessary to assure Medicare's solvency and to hold down costs over the long term.

To be sure, significant short-term savings can be achieved through various competitive approaches and the right kind of changes in benefit designs. Last year, the Chicago Teachers Union and the Chicago Board of Education trimmed $3.9 million from a proposed $12.9 million increase

in health insurance premiums by negotiating limitations on weekend hospital admissions, mandatory second opinions for elective surgery, financial incentives for ambulatory surgery and pre-admission, out-patient testing.

Similarly, AFT locals in Florida, New York and elsewhere have taken the initiative in negotiating health plans that include PPO's, HMO's and other alternatives to traditional health care services. The Federation of Nurses and Health Care Professionals, AFT's Health Care Division, represents employees of Oregon's Kaiser Health Plan, so we know first hand the cost savings and quality of care advantages associated with Health Maintenance Organizations. On the national, state, and local levels, the AFT has been actively involved in the promotion of cost containment through collective bargaining efforts that include the right kind of benefit restructuring, utilization review, improved data reporting and collection, more effective and responsive insurance administration, alternative delivery programs and responsible competition strategies.

But while the cost savings realized through competition, benefit restructuring and improved plan administration are not inconsequential, they occur primarily at the margins, and exert no permanent comprehensive control over prices.

In truth, free market analogies do not apply to the health care system, where most procedures, interventions, goods, tests and services

are not controlled or ordered by individual patients but rather by physicians. In fact, the effect of hospitals competing for physicians and patients in the world of unregulated competition might be to raise rather than lower costs; and with the entry of giant proprietary conglomerates into the PPO, HMO and Home Health Care Sectors, it is reasonable to predict a trend toward rapid acquisition, consolidation and concentration, followed by continued inflationary, profit-taking and anti-competitive behaviors characteristic of industries in which the market is controlled by a limited number of powerful corporations.

While the AFT generally supports responsible competitive approaches, we are also aware of their limitations. Competition alone is insufficient to assure affordable, accessible and high quality care over the long term.

We support the Kennedy-Gephardt Bill because it offers a comprehensive, fair and effective alternative to our current system of health care finance. Inclusion of all providers and all payers assures effective control of expenditures while preventing the unfair shifting of costs among consumers and purchasers of care. It would also assure financial help for hospitals that provide a high volume of unreimbursed and charity care.

This legislation promotes competition and individual state initiatives but within a broader framework that assures that the benefits of competitive initiatives will be sustained far into the future. The bill permits sufficient flexibility to encourage states to shape programs best suited to their

individual needs.

Finally, we support this legislation because it assures the solvency of the Medicare program without further penalizing its beneficiaries.

We support this legislation on the grounds of equity and effectiveness and urge that you act upon it favorably.

Thank you.

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1/ World Health Systems: Lessons for the United States: A report presented by the Chairman of the Select Committee on Aging, U.S. House of Representatives, May 1984.

2/ State Employee Health Insurance Plans: A Summary of Coverage, Benefits, Financing, 1983. Martin E. Segal Company.

3/ Health and Life Insurance Benefit Plans: Personnel Policies Forum Survey No 137. Bureau of National Affairs, March, 1984.

4/ An industry study, reported in American Medical News, February 24, 1984, found that of 20 states surveyed, only one had not experienced hospital worker layoffs in connection with health funding cutbacks.

5/ Evaluation of the 1981 AFDC Changes: Initial Analysis. U.S. General Accounting Office, April 2, 1984.

6/ Donald E.L. Johnson, "Survey Plots 475 Chains' Growth" Modern Health Care, May 15, 1984.

7/ Newsweek, Oct. 31, 1983. Also see Arnold Relman "Investor-owned Hospital and Health Care Costs" New England Journal of Medicine August 11, 1983.

8/ R.V. Pattison and H.M. Katz "Investor-owned and Not-For-Profit Hospitals" New England Journal of Medicine, August 11, 1983.

Senator QUAYLE. Thank you.

Let's start with Mr. Davis. I wonder if you might comment on the impact of the allpayer rate setting proposal on some of the initiatives that are going on in the private sector right now. You have heard that half your panel there advocates going in that direction although you, to a great degree, and Mr. Joseph to some degree talked about some of the positive things that are going on right now. I just wonder if you might comment on the impact and the effect that you think an allpayers system might have on some of the positive things that you ascertain are going on in the private sector right now.

Mr. DAVIS. Yes. I think there would be two very brief comments. First of all, I think that the question is: How can we identify a process that ultimately assures us of the fairest prices? And it just depends upon one's point of view as to whether or not someone in an office somewhere, either in Washington or a State capital, has the foresight or 20:20 vision to say, "This is what is a fair price," as opposed to a process that encourages multiple providers' coming to a business or an insurance company or a coalition at a community level and saying, "Here is the kind of health care we would be willing to deliver at this price."

I can't emphasize enough, Senator, the extreme amount of competitive information from providers that is coming to business. I received yesterday in the mail an offer from a firm in California to obtain, for 300 geographic areas in the United States, hospital and physician data 21 ways from Sunday. The approach is, therefore, to let us determine what is the price that we believe is the fairest price to pay for the kind of service we believe our employees should have.

We think that is an important freedom and one that, in the long run, will generate a greater rate of reduction in the increase in health care prices and spending than any one person's view of what is right. We are very much impressed by the ability of various plans like Blue Cross and other insurers to base a DRG system on community experience or State experience. We find that, in the long run, the more competition you can encourage, the more responses we get from the providers; and the more responses we get from providers, the larger difference in prices we get. The greater difference in prices we get, the lower the prices go.

I say, let's let the marketplace show it can't work before we turn the other way.

Senator QUAYLE. Do you think that the imposition of an allpayers proposal would have a disincentive to some of these things that are going on right now?

Mr. DAVIS. I am sure it depends upon the specific; but conceptually, it seems to me, if it says to people in the private sector, "You can only pay so much for this particular type of service," that may or may not be what we wish to pay. We may find that it would be better to support a certain level at a teaching hospital for a type of service that may or may not be reimbursed at the particular rate. We are already hearing that the administration is considering eliminating technology incentives from the DRG rates, and we think that that is fine if that is what the administration wishes to do for certain recipients; but there may be those in the private

sector who believe that supporting innovation and technology through health care prices is an appropriate investment in future cost—control.

Senator QAUYLE. Mr. Joseph, do you have anything you want to add to that?

Mr. JOSEPH. I would also like Mr. Oxfeld to respond, but let me just say that we are extremely bullish on the amount of progress that is being made in the voluntary sector on the part of business and local groups getting together and working out prices. The coalitions that I mentioned number some 750 today. They only numbered 25 two years ago, and we have been pushing this concept for half a dozen years. It is starting to really mushroom and we really see a lot of activity taking place as people try to work at the local level to bring together all the people around the table and try to figure out how they can best contain their costs.

Mr. OXFELD. I would just like to underscore what Jeff said and what Mr. Davis said earlier about the debate over whether the Government is really in a good position to know what is a fair price. The debate that I read in the paper every day over the DRG rates and whether or not those are truly a fair system of rates, I think, underscores the difficulty of having the central Federal Government set a uniform nationwide system of rates.

To the extent that you take away the incentive for business groups to bargain for the prices and services they need, I think that it will deal a perhaps fatal blow to the growth of these coalitions.

Senator QUAYLE. Mr. Greenwald, I was interested in your breaking down of the dollar contribution of health insurance premiums. Was it $500 per car or something about that figure? And also you showed the discrepancy of what we pay here in the United States and what they pay in Japan. I think that the average in Japan was somewhere around $1,300.

Mr. GREENWALD. $800.

Senator QUAYLE. There is an $800 discrepancy?

Mr. GREENWALD. No, ours is over $5,000 per employee and theirs is about $800 per employee.

Senator QUAYLE. I was thinking as I read Mr. Iacocca's speech a few weeks ago before the League of Women Voters in Detroit, and he had two things that he wanted to put through to get on a level playing field with Japan. One was to do something about the value of the yen which he remarked was about 25 percent underappreciated, and also to do something about the commodity tax that they have. I suppose that this might be a third item that he might want to talk about as far as getting that level playing field.

The question I have for you, and I noticed in your statement you indicated that all of us have to be in this. You mentioned that the management-labor agreements that have been signed in the past have certainly had a part to play, but you sort of asked for some assistance from the Government in getting to where you want to go on the cost aspects of the health coverage that you want to afford your employees.

Mr. Davis just remarked that he has gotten a lot of information recently of different things, that he had never seen so much information coming in as far as plans. I wonder particularly about the

figure you used, I think it was $3.2 billion, if you have all three of the auto companies combined, and you at Chrysler spend $400 million. I think in your written statement you called it clout, and it is clout. I wonder why it wouldn't be advisable to follow along what, although the medicare is obviously bigger, but you are a fairly big fact in this, and go out and really put the squeeze on some of these people out there in the market and really bargain on what kind of coverage you are going to get and for what cost. Mr. Helms was talking about the prudent buyer. That is the way they operate. I just wonder if that wouldn't apply to some of the larger companies.

In my conversation with Congressman Gephardt, I also alluded to that possibility. I just wonder if that isn't certainly an avenue that could be pursued.

Mr. GREENWALD. Senator, I share Mr. Davis' view that bringing the marketplace to bear, giving a company like ours the opportunity of seeking good quality service to be able to select among providers will have a material impact on the efficiency of health care services. However, at present we, like many large employers in the United States, with union contracts, have over the years found that our health care plans have two important ingredients in them. One, the employer pays from dollar one, and two, the employee has the privilege to select any provider that he or she chooses.

Senator QUAYLE. Don't you think we are going to have to change that?

Mr. GREENWALD. At present, the difficulty that we are facing in persuading our employees and the UAW to change, to give us the ability to go out and seek the best providers is that they would argue that it is unreasonable to ask any of our employees to travel 10 or 15 miles to get service, especially under emergency conditions. While we may be able to satisfy their needs in some of our communities where we are dominant, we clearly will not be able to nationally because we are one among many employers, we are one among many of those who receive services in hospitals and among doctors.

Therefore, I come back to a view which says, this needs to be thought through for all those who use the services of hospitals and doctors in a community, not just the major companies or the small businesses or the medicare service or the State service.

A second factor, I would submit, that will not be solved by the marketplace alone in the private sector is that, like it or not, the medicare system is running out of control. Something will have to be done, and if that something results in shifting the cost of medicare to the private employer, nothing will have been accomplished.

Finally, there is the open question of who pays for the necessary services of medical education, new equipment in hospitals, and the indigent? It is not good enough to say, well, if medicare chooses not to include in its rates education of doctors and the cost of hospitals that provide education, maybe the private sector would prefer to. I can tell you right now, given a choice, I don't prefer to. I have one active employee for every retiree now, and I have $5,700 per active employee to pay. Believe me, when I go face the Japanese to compete, I don't prefer to carry on more than my fair share of educating doctors in the United States although that education is clearly needed.

That is why, in our opinion, a commission that involves all the parties needs to work on a plan that will work.

Senator QUAYLE. Mr. Davis, do you want to comment on that?

Mr. DAVIS. I would just say that I think the issue is one, long term, of corporate reponsibility. I think it is not enough for us in industry to look at our own costs and, in a sense, try to cut our best deal just for us or our employees. I think we have a responsibility through coalitions—at the community level, primarily—to really address the question of, How do we make sure that the indigent and the needy in our communities get care?

In my judgment, the best way to go about that is being shown in our private sector work—that is, to utilize our community influence and our general leverage to make sure that the municipal tax rates, et cetera, do care for those needy. That is going to mean, to some extent, an economic impact upon us. And it may mean that it puts us at a competitive disadvantage; but, in the long run, I think we in business are going to have to take a look at. Where do we find a way to be efficient and, on the other hand, socially responsible?

I couldn't comment on the cost-accounting practices of other companies, but I am familiar with one company that operates in Japan. My analysis suggests that, while we can see significant differences in the cost per employee between the two countries, a very significant portion of the general-revenue taxation that we pay in Japan goes to fund a national health system that is above and beyond any payroll tax deduction or direct-benefit plan. So, it is not at all clear to me if we are really comparing apples with apples when we are looking at international market competition comparative analysis in health-care costs.

Senator QUAYLE. Senator Kennedy does have some questions that he is going to be submitting. That is all the questions I have; and Ms. Owley, since this is your first hearing—oh, did you want to comment?

Ms. OWLEY. I just wanted to comment on the freedom of choice and prudent buyer aspects that you mentioned from an employee perspective and what we would like to see. I think, as you said, won't freedom of choice have to go in terms of the physician that you have as an individual and isn't it true that a large group can be a prudent buyer? I think it is true, but it is not true under our current system. It is absolutely not true in a system where a decision cannot be made because how do you analyze what you are buying. How do you analyze whether this hospital is more efficient. If, for instance, I can have a hysterectomy by one physician who has a lower rate but takes me to a hospital that has a higher cost and keeps me in longer, then what have I gained as a prudent buyer? That is not even accounting for the fact that in all probability I didn't need the hysterectomy to begin with.

So, there are too many factors there that we, collectively, I still believe, are too ignorant of a system without sufficient and uniform data collected throughout this country whereby we can make all those intelligent decisions as a group. I probably would be more than willing to change physicians, even though they had been in my family for years, for instance, if you could demonstrate to me that his mortality/morbidity rates were higher for certain proce-

dures and he was not as capable of a physician, or that this hospital actually had higher rates of infection, or something along that line. But until you have some uniform data like that by which you can actually make some comparisons, how on earth do you really purchase cars or any other service unless you have sufficient data by which to make that decision? I think we are really missing that in the country.

Senator QUAYLE. That is one of the things that we are working on in our incremental approach is how do we get more information out there. I think that is a good question. As a matter of fact, I asked Dr. Helms this morning about some examples in Minnesota, Iowa, and Utah, where they have some rather sophisticated government/private and private organizations that give out these pieces of information. I think that whether it is the individual who has this information it would certainly be beneficial, whether it would be a company that would have this information to go out there, but we are going to have to, and I think this is what Mr. Greenwald says and why they advocate this commission, it is going to be all encompassing. We are all in this thing. We start pointing the finger at one and all of a sudden it is pointed right back at us. That is why my strategy is to approach this thing in a very much more of a rifle approach rather than a shotgun approach to try to make it work and to make it more efficient.

Thank you all very much.

Our next panel is David Markson and Donald Peterson.

The committee will be in order.

Mr. Markson.

STATEMENT OF DAVID F. MARKSON, PRESIDENT AND CHIEF OPERATING OFFICER, BLUE CROSS OF GREATER PHILADELPHIA

Mr. MARKSON. Thank you, Senator.

Mr. Chairman and members of the committee, I am David Markson, president of Blue Cross of Greater Philadelphia. My comments today reflect our experience serving over 2 million subscribers in southeastern Pennsylvania. I am also submitting formal written testimony for the Blue Cross and Blue Shield Association, a national organization of the 96 Blue Cross and Blue Shield plans.

We would first like to compliment you and the committee on recognizing the growing strength of private-sector market forces. We believe that your proposals for the expansion of alternative delivery systems, and preferred provider arrangements, and for promoting the development of better information for consumers are steps very much in the right direction. We share your interest in encouraging only the most appropriate uses for rapidly developing and frequently expensive health-care technologies.

As a major competitor in the health-care financing marketplace, Blue Cross and Blue Shield plans have developed a variety of cost-containment programs that are both effective and sensitive to the preferences of our customers and the needs of the public. In doing so, we have been guided by the philosophy that such programs should concentrate on eliminating unnecessary costs and utilization without being unduly restrictive to either individuals seeking care or to efficient providers who specialize in needed services,

such as hospitals with heavy teaching responsibilities as well as those providing specialty care or serving an inner city, rural, or otherwise medically underserved population.

The perceptions and concerns of Blue Cross of Greater Philadelphia may be different from others that you will hear. In part, that may be because we, as a community-oriented nonprofit organization play a unique role in our interactions with the key participants in the health-care system. We work interactively and interdependently with hospitals and doctors, business and labor, Government and our subscribers to change the behavior of the health-care delivery system so that it becomes more effective without sacrificing quality of care or access to that care.

We raise serious questions, Senator, and concern about broad reaching hospital rate and revenue regulation such as an all-payers system. We know that the complexities of our health care delivery and financing system require a comprehensive cost-containment program directed at the root causes of unnecessary cost and utilization. The all-payer regulatory approach has been seriously questioned in those States which have implemented rate regulation. A State-regulated all-payers system may fail to reduce cost increases and also stifle private-sector initiatives at the same time. Additionally, at the Federal level, the current changes to the medicare-payment mechanism are just beginning to be implemented.

The fundamental changes in the medicare- and medicaid-payment systems which are currently being implemented are predicted to have the most profound and far-reaching impact since the emergence of these programs almost 20 years ago. We at Blue Cross and Blue Shield are hopeful that these changes will be effective in containing the rate of increase of health-care costs, but we are concerned that they may produce savings at the expense of access to needed quality of care, especially by the poor or elderly.

Will they result in the closure of hospitals or the cutback of services, particularly in the inner cities and other medically underserved areas? Will the changes lead to a two-tiered system of health-care delivery and a double standard of health care?

Based on recent experience in States with an all-payer rate regulation mechanism, we fear that the costs actually increase as providers adapt to the new rules and become adept at gaming the system. In those regulated States which have shown progress in unit-cost trends, the overall cost has increased more rapidly because those gains are more than offset by increases in capacity, utilization, and services.

We are hopeful that these changes will produce a more competitive health-care delivery system and that they will encourage cost-containment approaches by the private sector, but we must add our concerns to other experts who have expressed thoughts that innovation may stagnate in an atmosphere of excessive regulation.

It is becoming increasingly clear that all-payer rate regulation has not been effective in those States which have experimented with it. A growing number of authorities, such as Jack Meyer, director of the renowned American Enterprise Institute Center for Health Policy Research, has observed, and I quote:

> We must be wary of regulatory fixes which promise short term savings and that a market oriented approach holds more promise than a controls approach for deceler-

ating health care cost increases while preserving the quality of and access to care so highly valued by health care consumers.

In Meyer's study, entitled "Passing the Health Care Buck," which we are making available to the committee, he points out that under ratesetting, there is no innovation, no price competition, nor are there incentives for patients and physicians to restrain use.

The efforts of the Blue Cross and Blue Shield plans, however, in the private sector have been extraordinarily successful in producing constructive and progressive change. In the important area of in-patient hospital utilization, the most expensive component of health care, the financial incentives and disincentives negotiated by Blue Cross of Greater Philadelphia have actually changed the behavior of the system for the benefit of its subscribers. According to a recent Johns Hopkins University study, which is summarized by the chart we are providing to the committee, the utilization of in-patient hospital care has declined substantially for subscribers of Blue Cross on a national basis and for subscribers of Blue Cross of Greater Philadelphia in particular.

This occurred during a period of increased hospital utilization for a comparable population on both a national and a regional basis. When compared to States with an all-payer rate regulation program, the results have been even more dramatic. The success, we believe, has occurred largely through the private-sector efforts of Blue Cross and Blue Shield plans in offering cost-effective benefits and by negotiating incentives and disincentives with providers.

These initiatives include increased short procedure units or same-day surgery; preadmission testing; preadmission certification; home health benefits; limitations on weekend admissions; expansion of out-patient benefits, such as out-patient chemotherapy, to name but a few.

Private sector initiatives in the area of data——

Senator QUAYLE. Mr. Markson, I have to interrupt you. Your 5 minutes have expired. We will have your whole statement in the record.

Mr. MARKSON. Thank you very much.

Senator QUAYLE. I am sorry, but otherwise we are never going to get finished. I have my little red light. When that goes on it means your 5 minutes are up, and I let you go on for about 30 seconds more or a minute, but we will have your full statement put in the record.

[The prepared statement of Mr. Markson and response to questions submitted by Senators Hatch, Grassley, and Kennedy follow:]

TESTIMONY

OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

COST CONTAINMENT STRATEGIES

BEFORE THE

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

PRESENTED BY

DAVID S. MARKSON

PRESIDENT

BLUE CROSS OF GREATER PHILADELPHIA

JUNE 20, 1984

39-881 O - 84 - 9

Mr. Chairman and Members of the Committee, I am David Markson, President of Blue Cross of Greater Philadelphia. I am here representing the Blue Cross and Blue Shield Association, the national coordinating organization of the 96 Blue Cross and Blue Shield Plans. We appreciate the opportunity to share our views with you on the appropriate role of the federal government in addressing the problems of increasing health care costs.

I would first like to compliment you on recognizing the growing strength of market forces and pursuing a legislative strategy designed to utilize these forces for the public's benefit. We believe that your proposals for fostering development of alternative delivery systems and preferred provider arrangements and for promoting development of better information for consumers are steps very much in the right direction. We share your interest in finding only the most appropriate uses for rapidly developing and frequently expensive health care technologies. Finally, we encourage you to continue to develop proposals targeted at preventing disease and promoting good health habits.

We believe that the cost-containing dynamics of a competitive marketplace offer not only the best promise of controlling the price of hospital inpatient services, but of assuring that the much needed incentives for delivering care in the least costly setting are in place. The emergence of these new dynamics, however, are sure to be disrupted by any attempt to introduce broad based government regulation into the system.

As a major competitor in the health care financing marketplace, Blue Cross and Blue Shield Plans have developed a variety of cost containment programs that are both effective and sensitive to the needs and preferences of our customers. In doing so, we have been guided by the philosophy that such programs should concentrate on eliminating unnecessary costs without being unduly restrictive to either individuals seeking care or to efficient providers with special needs, such as hospitals with heavy

teaching or charity care responsibilities. We are concerned that improperly directed cost containment efforts can undermine the quality of care or inhibit access to necessary services. Effective, long-term cost containment will depend upon the establishment of incentives in the existing marketplace that are based on efficiency and cost effectiveness in the delivery of quality health care.

Last year, the Blue Cross and Blue Shield Association provided detailed testimony to this committee on specific programs underway in the various states. For now, we simply want to point out that initiatives by Blue Cross and Blue Shield Plans to develop effective cost containment programs have:

- o lowered subscriber inpatient hospital utilization;
- o reduced medically unnecessary procedures and tests;
- o encouraged the provision of care in less costly settings;
- o helped moderate capital expenditures; and
- o fostered the development of successful alternative delivery systems.

Based on our extensive experience in developing innovative approaches to controlling health care costs, the Blue Cross and Blue Shield Association believes that the free and effective operation of market forces in a properly structured competitive marketplace is the best approach to health care cost containment. The fundamental forces of a market environment, which serve to keep checks on the elements of supply, demand, and cost, are essential to the philosophy upon which our economy operates. Until two years ago, it appeared that the health care marketplace was insulated from the dynamics of these forces and there were pressures to remove the regulatory impediments and construct a framework more conducive to competition. However, over just the past

two years, the forces of supply and demand have emerged as a result of increased price sensitivity on the part of the health care consumer. The interest and growth in the membership of HMOs, burgeoning preferred provider arrangements (PPAs); and the increasing number of free-standing surgical and emergency care centers are all the results of the current scramble by providers who are competing in their efforts to offer care in lower cost settings.

Purchasers of health care, as well as providers, have increased their level of sophistication in a very short time. The concepts of prudent buying and selective contracting are becoming increasingly common concepts among employers. The Business Roundtable's Task Force on Health just reported that, as a result of various steps taken by its members, average health care costs per recipient for the first quarter of 1984 increased only 8.4 percent from the first quarter of 1983 compared with 12.7 percent for the same period a year earlier. A number of strategies have been employed by corporations seeking to reduce employee health care costs without reducing the quality of care. Companies have established utilization review programs and are using data to uncover overuse of benefits as well as to identify cost-effective providers. They have also redesigned benefit options, with many firms placing particular emphasis on preventive care and the use of non-hospital based facilities. Blue Cross and Blue Shield Plans have participated in many of these developments in cooperation with our customers.

For example, in the important area of inpatient hospital utilization, a recent Johns Hopkins University Study reported that the utilization of inpatient hospital care declined substantially since 1970 for Blue Cross and Blue Shield subscribers on a national basis and for subscribers of Blue Cross of Greater Philadelphia, in particular. This decrease occurred during a period of increased hospital utilization for a comparable population

on both a national and a regional basis. When compared to states with an all-payer rate regulation program, the results are even more dramatic. The successes have occurred largely through Blue Cross and Blue Shield Plans offering cost effective benefits and negotiating incentives for proper utilization with providers. Innovations which contributed to this decline in utilization include: increased short procedure units (SPU) or same-day-service utilization; pre-admission testing; pre-admission certification; home health benefits; expansion of outpatient benefits, and utilization review. New programs to reduce unnecessary surgery and to limit unnecessary diagnostic procedures are being announced by the national Blue Cross and Blue Shield Association on a regular basis. Private sector initiatives in the areas of utilization data analysis and coalition building to affect behavioral changes have also been implemented in the Philadelphia metropolitan areas. Blue Cross of Greater Philadelphia and Pennsylvania Blue Shield, working with the public, labor, and providers, has developed a utilization analysis of 300 thousand workers. In addition, the fixed annual hospital utilization report developed by the Greater Philadelphia Chamber of Commerce, the PENJERDEL Council, and Blue Cross and Blue Shield, was released last month. A similar report for the membership of 23 Philadelphia labor organizations has been developed with the cooperation of the Philadelphia Council, AFL-CIO. Our most recent effort in Pennsylvania is our newly launched comprehensive health care cost containment program. I am happy to furnish the committee with copies of this program. These cost containment activities and others by Blue Cross and Blue Shield Plans across the country came about because of the competitive private sector forces growing in the health care delivery and financing environment.

A price-competitive marketplace will recognize and encourage the development of these and even more diverse approaches which take into account such elements as provider practice patterns, customer attitudes, and employer and employee preferences.

While we support a marketplace approach to controlling health care costs, we do recognize that there is a role for regulation in structuring that marketplace. Assurances of the quality of services, access to care, and control of major capital expenditures in areas where competitive forces are just beginning to emerge are all necessary. These "safety nets," however, should not interfere with the development and operation of price competition.

On the other end of the cost containment spectrum is the approach of regulating inpatient hospital costs. The Blue Cross and Blue Shield Association believes that cost containment strategies which focus primarily on payment for hospital inpatient services to hospitals — while correctly identifying the largest single component in the increase in health care costs — fail to provide the incentives necessary to develop alternatives to hospital-based care. Our concern about the efficiency and effectiveness of government-imposed hospital rate regulation rests on five points:

1. Regulation is likely to impede the cost containing innovations underway in today's health care financing marketplace.

2. It would let many participants in this industry avoid their responsibilities for health care cost containment.

3. It would not eliminate the practice described as "cost shifting" but, in fact, would institutionalize it.

4. Regulation is based on very limited empirical evidence that such total regulation has a significant effect on prices, and no evidence that it provides major incentives to restructure the delivery of care.

5. It would disrupt the evolution of the government's role in health care financing.

As I elaborate briefly on each of these points, I would like to assure you that we do appreciate the dilemma which you face. However, we do not believe that a regulatory approach would resolve the basic problems involved in containing the cost of health care in this country.

Effect on Current Marketplace Innovation

Comprehensive hospital rate setting inhibits and often precludes the cost containing innovations that have begun to multiply rapidly in today's health care financing marketplace. An amazing diversity of creative responses to cost problems has sprung up in just the last 24 months. The concepts of prudent buying and selective contracting are increasingly accepted and the Medicare prospective payment system will spark other price-driven systems. These developments are already stimulating changes in the relationships of hospital to physician and payer to provider. Importantly, they are providing the key incentives to reduce excess capacity. Major purchasers are "shopping" and negotiating on behalf of their subscribers and hospitals can no longer carry the cost of their excess capacity and be competitive. Rate regulation, because it is generally premised on guarantee that the full financial requirements of hospitals will be met, would not address excess capacity without yet another regulatory — and political — framework.

As just one example of competition, I invite you to consider the current environment in California, where those dynamics are currently at work. The health care marketplace in California, where hospitals have had a state-wide average occupancy rate of less

than 60 percent, is currently responding to the challenges of the new MediCal system, the onset of the new Medicare prospective payment system, and a flurry of preferred provider arrangements, including those sponsored by Blue Cross and Blue Shield Plans. Negotiations for "preferred rates" are underway all over the state. Preliminary results show a dramatic reduction in the prices to be charged by participating hospitals and the beginning of a much needed adjustment in the number of hospital beds. With that kind of dynamic unfolding, now is not the time to freeze health care institutions in their current position -- as governmental regulation must inevitably do.

Competitive Relief for Payers and Providers

The introduction of hospital rate regulation would destroy the powerful incentives that Blue Cross and Blue Shield Plans, employers of all sizes, unions, and insurers now have to search for more cost-effective means of providing health care. Competition is currently fueling the development of new alternative delivery systems which promise quality care at a lower price. The major responsibility and accountability for "cost containment" should not be shifted to a regulatory agency of government or to individual subscribers through high cost sharing. We believe that the marketplace forces now unfolding can and will do the job more creatively and effectively than any governmental program.

Institutionalization of Cross Subsidizations

The regulation which results from hospital rate setting would do nothing to prevent the practice of so-called "cost shifting" and, indeed, would institutionalize such practices in ways which are often not fully understood.

In the last few years, the commercial insurance industry has conducted a nationwide campaign against "cost shifting." The campaign is designed to foster the establishment

of rate setting, or all-payer, systems to preclude third party payers from negotiating to pay less than what a hospital decides to charge for services. Indeed, a "cost shift" is more accurately described as a differential in what purchasers of health care pay for services. The differential arises primarily from the fact that some purchasers negotiate payment rates with hospitals (or, in the case of the government, simply offer specified payment terms). These negotiations usually call for payments related to the actual costs incurred by a health care plan's subscribers or enrollees. Generally, the negotiations revolve around identifying whether the cost incurred by the hospital are reasonable and relate to the service provided to the subscribers. Payers that negotiate include Blue Cross and Blue Shield Plans, HMOs, PPAs, and some commercial insurers through their own HMOs or PPAs.

Other payers, however, will pay whatever hospitals charge for services. The major adjustments which may be included in those charges generally fall into two categories: (1) costs that are inappropriate or unnecessary; and (2) lost revenue such as the hospital's bad debts.

Rate setting programs do not assure that the amount an insurer pays is related to the cost of the services actually provided to its subscribers and that the amount an insurer pays is related to the efficient operation of the hospital. It is important to realize that the hospital's charges may be set so as to cover a variety of existing or planned investments that are not necessarily related to patient care. These costs should not be assumed to be the responsibility of the insurer.

The other general category of costs -- bad debts -- results from treatment of patients with no insurance, or those with inadequate insurance, who cannot or will not pay the out-of-pocket amounts owed the hospital. Rate setting programs generally address the

bad debt problem by merely distributing among those who do pay — primarily employers who provide health benefits to their employees — the financial burden of the underinsured and the uninsured, who fail to meet their obligations. How to deal with bad debt should be a major public policy decision but often is not considered when states debate the all payer alternative. It is not until employers realize that they may be responsible for financing a state reduction in Medicaid benefits or subsidizing hospital-based community programs that they understand the full effect of the new program. Finally, the treatment of bad debts under rate setting programs can reduce the hospital's incentive to pursue collection of bad debts and can reduce the federal and state government's incentives to maintain benefit, eligibility, and payment levels in their programs.

Lack of Evidence Supporting Rate Setting

Effective, long term cost containment requires a set of incentives that will promote more efficiency and cost effectiveness in the delivery of health care and, importantly, will lead to reduction in excess capacity. In our experience, and in the view of many experts on this subject, the rate setting programs already in operation do not in fact create such incentives. Rate regulation does appear to create incentives to outmaneuver the system, to match accountant for accountant and lawyer for lawyer. In our view, a more productive set of incentives would flow from a price competitive marketplace. In addition, I would emphasize that research on the current regulatory programs is very clear on one finding: such programs do <u>not</u> produce rapid results. We believe that marketplace dynamics now evolving will move more swiftly than the regulatory alternative.

The Latest Reform of Medicare Needs Time to Work

Finally, to intervene at this point in the evolution of the government's role in health care financing is premature. The federal government is becoming a more prudent purchaser as evidenced by implementation of Medicare's new prospective payment system. The impact of this on provider behavior is already producing results every bit as dramatic as those that developed in the mid-1960's when federal and state governments began the commitment to finance medical care for the elderly and poor. We understand and support that evolution and urge that this newest step be given an opportunity to take complete effect. There are strong indications it is indeed working as intended and forcing all segments of the health care system to re-examine their performance in the marketplace.

Our comments on and concerns about regulatory programs also apply to the approach of creating strong incentives for states to adopt a defined cost containment program — either regulatory or competitively based — and then measuring their performance. The Medicare Solvency and Health Care Financing Reform Act, S. 2424, takes such an approach. The basic structure of the bill is establishment of a federal prospective payment system phased in over time. States are given the opportunity to develop their own qualified plans as alternatives. Should a state fail to develop its own plan or fail to meet federal guidelines, then the federally administered all-payer program becomes effective.

S. 2424 is complex and we have many concerns, both general and specific. At this time we will only comment on our major concerns:

1) Competitive Solutions Won't Be Given A Fair Chance

Once the government puts itself in the position of measuring the performance of states, it is inevitable that it must "regulate" by defining its method of measurement. The government defines the unit of measurement — in this case revenues per discharge and total revenues — and defines what is in the measurement base — the base year — and what is not. Exceptions and adjustments are defined. Finally, as is almost inevitable, major public policy decisions are made even for states which "develop their own programs" by spelling out what must be included in their program, for example, and full payment for hospital bad debts.

This is not allowing the marketplace a fair chance nor is it allowing the states to design their own programs.

2) S. 2424 May Increase Costs Rather Than Contain Them

The focus of S. 2424 is on hospital services. The bill assumes that hospital administrators are passive and will continue to conduct business as they always have regardless of any changes in payment. It is difficult to speculate on the response that will occur, however, our early experience with Medicare's Prospective Payment System (PPS)is instructive. The unbundling of hospital services into non-regulated settings has already begun under PPS and is a likely outcome of measures like S. 2424. Hospital administrators may shelter many of their hospitals' services from regulatory oversight through corporate re-organization and redesign. Radiology, pathology, laboratory services, and emergency room services all may be broken out from the hospital and established as free-standing wholly-owned

subsidiaries. The all-payer system that would ultimately be imposed might be able to rein in inflation in the hospital industry, but it would be a hollow achievement. Hospitals would have sheltered or split away most of their revenues only leaving a small set of services subject to all payer scrutiny. We suggest that the result of this would be unconstrained price inflation for the unbundled services. Ultimately, systemwide health care costs would increase as hospitals undertake complex and complicated corporate restructurings.

3. It Is Premature and Possibly Infeasible to Include Physician Payment As Part of The DRG Price.

We support the objective of constraining physician price inflation. However, it seems to us that it would be premature to embark on such a major system change when the first results of the new Medicare system are just being observed. The dynamism of the competitive forces at work in the private sector are yielding returns and the prospective payment system has brought about significant changes in the hospital sector. Wholesale change seems particularly unnecessary now.

Before embracing a DRG-based approach, however, we need to know the answer to questions, such as: whether physician DRGs are necessary to alter physician behavior, and whether they are medially appropriate for physician reimbursement?

Summary

In summary, the Congress, as well as a number of the states, are now deliberating their appropriate role in trying to bring health care costs under control. The range of roles under discussion varies from the administration of a comprehensive hospital rate setting

program to assuring that competitive forces are allowed to flourish without artificial restraint.

We believe that the most appropriate role for the federal government is to nourish competitive forces and, along with the states, provide for a residual regulatory framework — a safety net — to assure that the quality of care and access are preserved within a competitive environment.

ANSWERS TO QUESTIONS FROM SENATOR HATCH

1. **It has been asserted that our third-party payer system has contributed to escalating health costs. What is the impact of increasing competition for health care services on the third party system?**

Crucial to the strength and stability of this country's health care system is the dynamic balance among three critical elements — quality, access and cost. Once only quality and access issues seemed important, but today cost, or cost containment, is just as important. Responsible third party payers can and should be in the forefront of helping to maintain the balance among quality, access and cost, and increasing competition among carriers and other participants in the system should lead to striking such a balance.

The increasing competition in the health care marketplace has important implications for the third party payment system. Most significantly, it has raised the price sensitivity of all purchasers of health care including, very importantly, third party payers. This has led responsible third party payers to engage more and more in prudent purchasing and selective contracting to secure high quality health care services at the most reasonable cost for their subscribers. Increased competition among purchasers has also brought about greater competition among health care providers who are now scrambling to offer health care in lower cost settings. In addition, increasing competition has sparked innovation, such as the development of alternative delivery systems and new reimbursement methodologies. Again, the benefit of this accrues to all purchasers — individuals and third parties.

2. **What kind of programs are being initiated in the private sector to control health care costs?**

There are a wide variety of programs being initiated in the private sector to control health care costs. The six cost containment strategies which Blue Cross and Blue Shield Plans have found particularly effective in providing incentives for appropriate use in pricing of health care services are:

- o negotiated payment arrangements;
- o utilization control;
- o medical necessity evaluation;
- o health planning;
- o benefit design;
- o alternative delivery systems.

These certainly are not "magic bullets," and most of the programs must be implemented to fit local circumstances which differ in methods, cost and use of medical care. However, they do give evidence of private sector efforts toward innovation in the health care marketplace.

ANSWERS TO QUESTIONS FROM SENATOR GRASSLEY

1. **You noted that in some states, and I believe you mentioned California, excess hospital capacity is being reduced. Conceivably, in some places, this could mean that some hospitals might have to close. Do you have any perspective on the special problems of rural areas and rural hospitals? Specifically, I am concerned that serious hardship could result for rural areas in the event that some of these hospitals might have to close. Do you have any thoughts on this matter?**

   In our statement we did note that we are encouraged by the reduction in excess hospital capacity that is occurring as a result of competitive forces growing stronger in the health care marketplace.

   We recognize the concern that closure of rural and inner city hospitals could result in impaired access to health care. However, we believe a strong health planning program that promotes the orderly development and allocation of health care resources can provide the "safety net" to assure that citizens in rural areas have continued access to needed health care services.

   This is one of the reasons the Blue Cross and Blue Shield Association urges that federal support be continued for health planning at the state and local level.

2. **You noted in your statement that improperly directed cost containment efforts can undermine the quality of care or inhibit access to necessary services. Are you aware of any evidence that this is happening as a consequence of the prospective payment system introduced last year? For example, is there any indication that people, particularly older people, might be being discharged prematurely from hospitals?**

   While there is the possibility that the quality of care may erode under the prospective payment system just implemented for Medicare, we are not aware, at this time, of any evidence that it is actually occurring. The system is new and still in the process of being phased in and there are not sufficient data available upon which we can base any conclusions. However, because of the incentives built into this system it is very important that its implementation and operation be closely monitored so that premature discharges are avoided or unnecessary admissions do not take place.

ANSWERS TO QUESTIONS FROM SENATOR KENNEDY

1. You have given me a long list of activities that Blue Cross and Blue Shield member plans are doing to control costs. Is there anything on that list that you would be prohibited from doing under Kennedy-Gephardt?

Many of the cost containment activities engaged in by Blue Cross and Blue Shield Plans flow directly or indirectly from, or are a part of, the negotiations between Blue Cross and Blue Shield Plans and providers. In essence, an insurer's ability to develop negotiated payment arrangements or contracts would be significantly impaired under S. 2424.

The contracts negotiated by Blue Cross and Blue Shield Plans with providers are the principal means by which the Plans, acting on behalf of their members, use their members' combined purchasing power to establish access to services at fair prices. These contracts or arrangements do more than specify the level and method of payment for services provided to Blue Cross and Blue Shield members. At their best, they contain prices, improve utilization, encourage innovation and benefit both our members and those providers who contract with us. We do not have an "exclusive" on this kind of negotiation. But just like making cost containment programs work, it takes time, money, energy and skill to be successful. We believe our effort pays off for our subscribers and the community at large.

These negotiated arrangements also serve as the basis for plans and providers to test new or alternative payment programs. Such programs include, for example, the Maxicap prospective payment systems in Rhode Island and Rochester, New York; the capitation programs in North Dakota and Massachusetts; and payment incentives for physicians and hospitals in various states to encourage broader use of ambulatory care and the Preferred Provider Arrangements being developed and implemented around the country.

The consequences of impairing the ability of an insurer to enter into such negotiated arrangements would be a reduction in the leverage needed to implement some of the varied programs noted above.

2. Do you think it is fair for Blue Cross to use its market power to obtain discounts not available to everyone else, and doesn't this raise other payer's costs?

This is an important question and one which raises various complex issues. We will try to deal briefly with each of them in our response.

As prudent purchasers of health care coping with a diverse set of local needs and conditions, Blue Cross and Blue Shield Plans do not have a single payment arrangement. In some places we pay hospital established charges as do other payers. Elsewhere we pay costs plus a reasonable operating margin (i.e., profit). In other places we pay costs, plus bad debt of others and a share of profit. And, in some other areas of the country, we pay a price or series of prices (e.g., DRG, per diem, per discharge) based on peer groups or community norms.

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A Blue Cross Plan payment differential is not a discount, but a negotiated and responsible payment arrangement between parties at economic interest (the Plan and the hospital) and a sound business practice. Plans simply do not want to pay charges where the hospital and only the hospital determines what its own profits should be each year. Instead, the Plan enters into negotiation so that the Plan payment can cover a fair share of the cost and a reasonable operating margin related to the care rendered to the Blue Cross patient. In other words, this is an attempt to control what we pay. Wherever the resulting Blue Cross Plan payment is less than the charges set by the hospitals, we still pay costs plus a profit and nearly always a share of bad debt generated by other payers.

Nowhere is a Blue Cross Plan given special rights or legal authority to negotiate payment arrangements with hospitals. Other payers have the same opportunities. However, all payers may not want to devote the resources or develop the programs that provider payment negotiations require. Payers are different and the price they pay should reflect these differences — what is a fair price for one payer is not necessarily a fair price for another.

Blue Cross and Blue Shield Plans' marketshare is the result of strong commitments and successful track records in initiating effective cost containment and payment programs. Our market demands these programs from us. Since these efforts help us maintain and increase our share of the market we consider them a priority. we believe that's what competition is all about.

We depend on the right to negotiate, the right to get the best price for our subscribers and the right to work together with the hospital community. We have earned these rights and use them to fulfill our obligations to the 80 million Blue Cross and Blue Shield subscribers we serve. Our programs, not our "market power," result in better Plan-hospital payment arrangements.

What is being raised is the charges to others, not the costs, and not by Blue Cross Plans but rather by the hospitals. Again, Plans' payment negotiations result in the Plans paying costs of care for their subscribers plus operating margin and often a share of charity and the bad debt of others. While this may be less than charges, it certainly does nothing to increase the cost of hospital care of other payers. In fact, it probably reduces costs as negotiations may serve to limit what hospitals have available to spend and result in increased efficiency. As hospitals want their profits to increase they may raise charges to others who are not willing to commit the time and resources to effectively negotiate. What is a more likely cause for raising other payers' costs is the narrow coverage, limited range of services and shortfalls in benefits payments characteristic of non-Blue Cross patients. Furthermore, these non-Blue Cross patients generate far more hospital bad debt than Plan subscribers.

Finally, Blue Cross Plans generate less administrative costs and collection costs. We pay more promptly and through our efforts in the community attempt to limit unnecessary facilities and unnecessary hospital profits. We try to keep our rates down to permit more people to be covered. We work hard to have our subscribers utilize and pay for only necessary care in the lowest cost setting through medical necessity, pre admission and utilization review programs, encouraging alternatives to the inpatient setting.

We believe these payment and business practices make sense. We are acting as a prudent purchaser on behalf of those who choose Blue Cross Plans to represent

them in the health care marketplace. In fact, the cost containment and business practices of Plans around the country are more likely to reduce costs for other payers by increasing hospital efficiency and improving medical practice and delivery patterns. We do not intend and do not believe that our payment arrangements and other cost containment activities cause other payers' costs to increase.

3. **Why aren't you enthusiastically supporting Kennedy-Gephardt, when it will bring $70 billion in savings to the private sector over the next five years? Don't you have a responsibility to your subscribers that goes beyond preserving your discount?**

The Blue Cross and Blue Shield system, locally and nationally, is strongly committed to containing all aspects of health care costs for our subscribers and whenever possible, for the community at large. The success of our cost containment efforts is based on the diverse nature of our programs and not institutionalizing one or two individual approaches. Blue Cross and Blue Shield Plans' cost containment strategies are continuously refined to reflect changes in the environment, subscribers' interest, and community-Plan capacity. The foundation of these strategies is built upon our ability to link the various health care programs such as:

- Avoiding unnecessary use of health care services
- Ensuring reasonable payment for services rendered
- Encouraging appropriate use of less costly settings
- Offerring appropriate alternative health care delivery systems
- Capturing administrative savings through Other Party Liability programs
- Addressing community issues
- Encouraging healthy living

The result of our ability to bring these programs under one comprehensive cost containment effort is savings for our subscribers — substantial savings. In 1982, we were able to document over $5 billion annual savings as a result of Blue Cross and Blue Shield Plan cost containment programs. Our hospital payment programs alone represented close to $2 billion of the total savings. As a system, preserving this aspect of our total cost containment program is a responsible, sound objective, and one which we know our subscribers enthusiastically support.

Dollar savings for our subscribers is not the only objective we have in mind. Our programs help control utilization for all patients, identify medically unnecessary procedures for all patients, detect and stifle fraudulent activity for all patients, encourage the use of less costly medical care settings for all patients, audit and stop billing and clerical inaccuracies for all patients, and address community issues through coalitions, health planning and health education on behalf of all patients.

Our cost containment efforts require a substantial investment of time and resources. Obviously, we view these activities as a high priority and would look at your claim of an additional $14 billion in annual savings for the private sector with enthusiasm. However, it is not clear to us how these results can be achieved through regulation. In our experience, and in the view of most experts on this subject, effective, long term cost containment requires a set of incentives that will promote more efficiency and cost effectiveness in the delivery of health care and, importantly, lead to reduction in excess capacity. It is not clear that the rate setting programs already in operation do in fact increase such incentives. In our view, a more productive set of incentives would flow from a price competitive marketplace. We believe

the marketplace dynamics now evolving will move swiftly and would surely be disrupted by the introduction of broad-based government regulation. The concepts of prudent buying, selective contracting, prospective price negotiation, multiple consumer product lines, alternative delivery settings and health promotion are finally taking hold. These initiatives will do the cost containment job more effectively and creatively than any governmental program can, at least in most states. As one member of the private sector, Blue Cross and Blue Shield Plans are well on the way to making this happen.

Senator QUAYLE. Mr. Peterson, you may proceed.

STATEMENT OF DONALD M. PETERSON, PRESIDENT, BENEFIT LIFE INSURANCE CO., CHICAGO, IL

Mr. PETERSON. Thank you, Senator.

I am Donald Peterson, president of Benefit Trust Life Insurance Co. Today I also represent the Health Insurance Association of America. With me are Karen Williams and James Dorsch of the HIAA Washington staff.

I will briefly summarize my statement and ask that the full text be placed in the record.

We are pleased that you are addressing the issue of rising health costs following the passage of Social Security Amendments of 1983. We have supported prospective pricing for years and in this respect, commend the passage of H.R. 1900. The change in the way hospitals are paid under medicare probably would not have been proposed were it not for the persistent rapid increases in health care costs seen in recent years. However, these increased costs and their effects on Government programs are just as applicable to the insurance coverage purchased by employers for their employees and by individuals for themselves.

When medicare pays less, private payers pay more, in effect setting up a hidden tax on other hospital patients which we estimate will reach $8.8 billion in 1984. As a result of this cost shifting to private payers, group health insurance premium rates are increasing 15 to 30 percent annually. These increases are ultimately shared by employers, employees, and consumers and adversely affect the health of American industry.

The Federal Government's role as a catalyst has helped encourage variety and innovation in State all-payer cost containment systems. We believe this is the prime role for the Federal Government and should be continued. We commend the Congress for its recognition of qualified State programs as an alternative method of medicare payment under the Social Security Amendments of 1983. We ask you now to adopt positive incentives for the States to develop their own qualified programs for all patients.

We urge the Congress to take the next step in prospective pricing, to enact legislation extending a hospital prospective pricing system to all payers, not just medicare, such a system to take effect 4 years after enactment in any State which has not implemented a qualified State program. This would give every State sufficient time to enact legislation suitable to its own particular needs and yet guarantee that all our citizens get the protection they deserve.

Such a proposal need not, in fact, should not, require States to set up hospital rate setting commissions. It need not, and should not, require any particular type of program, rate setting, DRG, or

otherwise, as long as the State program meets the criteria set forth in the Social Security Amendments of 1983. It would provide a stimulus to those who believe our problems are best solved at the State level to move ahead and get the job done so there will be no need for a Federal all-payer program.

Another incentive could be a modest medicaid reward for those States which enact qualified programs similar to the reward in present law for States which had hospital cost containment programs in place on July 1, 1981. This would be a fitting way to attack a national problem at the State level without a new Federal bureaucracy. It would be an appropriate reward to those States which, by holding down rising health costs, are taking action to reduce the number of our citizens forced into medicaid and other public assistance programs by health care inflation.

On the other side of the cost containment coin, Mr. Chairman, the administration has asked Congress to levy a tax on employee health plans. The health insurance industry opposes this proposal as being not only discriminatory and unfair, but most significantly, as one that will do nothing to stop health care cost inflation. Specifically, it would penalize older workers, those in hazardous occupations, and those in high cost geographical areas. It would also result in a reduced availability of coverage for preventive care services. A prospective all-patient system, however, will force cost saving incentives into the structure of hospital pricing practices, and will have many times the impact of the band-aid approach of taxing worker health insurance premiums.

Clearly, our ideas coincide with some of the concepts expressed in S. 2424 introduced by Senator Kennedy and H.R. 4870 introduced by Congressman Gephardt. To that extent, we agree with the sponsors of those bills and applaud the initiative they have taken. All our citizens need relief from rising hospital costs, not just those on medicare.

We appreciate this opportunity to present our views. We will certainly be glad to work with the committee toward constructive solutions to the difficult problems we all face due to the rising cost of health care.

Thank you.

[The prepared statement of Mr. Peterson and responses to questions submitted by Senators Hatch and Grassley follow:]

STATEMENT

OF THE

HEALTH INSURANCE ASSOCIATION OF AMERICA

ON

HEALTH CARE COST CONTAINMENT STRATEGIES

PRESENTED BY

DONALD M. PETERSON

BEFORE THE

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

June 21, 1984

I am Donald M. Peterson, President of Benefit Trust Life Insurance Company. Today I also represent the Health Insurance Association of America. With me is Karen Williams and James A. Dorsch, of the HIAA Washington staff. The HIAA is a trade association of approximately 325 companies which together write over 85% of the country's commercial health insurance. We appear today on their behalf.

We are pleased that you are raising the issue of rising health costs shortly after the passage of H.R. 1900, the Social Security Amendments of 1983.

The recently enacted law serves as a good starting point for discussion of the issues. It changes Medicare's hospital payment for the present retrospective determination of incurred costs to a system of prospectively determined prices. We agree that this change in incentives is highly desirable. In fact, prospective payment may be our last chance for a competitive solution to rising hospital costs. However, the new prospective pricing system applies only to Medicare. Any system that does not apply to all patients will not produce the desired changes in hospital behavior.

The change in payment basis under Medicare would probably not have been proposed were it not for persistent, rapid increases in health care costs in recent years. These increases and their effects on government programs are just as applicable to the insurance coverage purchased by employers for their employees, by individuals for themselves, and by the self-insured. As a result, annual health insurance premiums are currently increasing at rates

which range from 15% to 30% depending on the size and location of the business. These increases are ultimately shared by the employers, employees and consumers and adversely affect the health of American industry.

A prospective pricing system which applies only to Medicare will admittedly hold down Medicare outlays, but hospitals could simply shift costs to other payers. If the change to a prospective system provides the right incentives to hospitals to voluntarily control health care expenses, and we agree that it does, such a change is equally needed by those who are not eligible for Medicare.

The existence of cost shifting has become well-documented since our industry publicly identified the problem a couple of years ago. Cost shifting totalled $5.8 billion in 1982. According to our latest estimates, the cost shift will grow to $8.8 billion in 1984.

As a logical business practice, hospitals recoup reductions in Medicare and Medicaid reimbursement by inflating charges to private patients. Those who are insured faced higher premiums. Those who are not - such as laid-off workers who have lost their insurance - are faced with a ruinous hidden tax exacted at a time when they are least able to pay - a tax on their already sky-rocketing hospital charges. Without government action on an all-payer system, all private patients remain vulnerable to an unprecedented and financially intolerable level of cost shifting.

In theory, prospective payment leads to cost containment because hospitals will work with physicians to voluntarily reduce length of stay and ancillary services. The incentive for such behavorial changes is profit; hospitals will finally be able to get more money for doing less. But hospitals say such changes take time and substantial effort. In practice, hospitals will find it far easier to cost shift than to cost contain.

We support federal legislation that effectively protects private patients from additional cost shifts. Such protection could take the form of a residual prospective payment system for all-payers. While such a system would provide cost containment incentives, it need not produce savings to the private sector in the short-run. Furthermore, an all-payer system would not necessarily require that all-payers initially pay the same price for hospital services. But discounts ought to be justified by savings to the hospital and be available to all patients. For example, discounts for prompt payment would be appropriate. As a practical matter Medicare could receive some special guarantees against program cost increases. Congress has already written into the law such a provision for any state system recognized by Medicare. Under the Social Security Amendments of 1983, if the Secretary of HHS finds that, over any three year period, Medicare has paid more under the state system than it would have paid otherwise, the Secretary may reduce subsequent Medicare payments to hospitals under that system by that amount.

I would like to shed some light on arguments against an all-payer system. The Administration says that we private insurers will piggyback on the Medicare DRG prices once we recognize that we are paying too much for

hospital care. Mr. Chairman, we already know we are paying too much but we are unable to pay less under a combination of current federal policies that generate cost shifting while prohibiting joint negotiation by insurers. We are caught between the competitive forces in the insurance market and the failures in the non-competitive hospital industry. Current comprehensive benefit contracts with employers would prohibit us from limiting our payments to hospitals to the Medicare rate because hospitals would bill employees for the difference. Employers and employees have made a conscious decision to elect comprehensive medical benefits in 90% of our group business.

If, in the future, an individual insurance company only offered to sell plans which limit benefits to the Medicare DRG rates, employers would again exercise their option in the free market to buy comprehensive benefits from another insurance company. What if the federal government intervened in the competitive health insurance market and prohibited the selling of comprehensive medical benefits; would you then indirectly succeed in controlling hospital costs? No, hospitals would charge patients all that the market would bear above the indemnity amounts. Many hospitals would soon find their solvency threatened as bad debts amounted.

You may ask whether we negotiate with hospitals to accept less than their charges as full payment. Hospitals have agreed to such requests to voluntarily reduce their revenues only where an employer or insurer has sufficient volume to force acceptance. Some Blue Cross plans so dominate their local areas as to be successful in obtaining such volume discounts. For the vast majority of the country, however, neither the insurance company nor

the employer has sufficient local volume to negotiate charges and thereby prevent cost shifting. To drive home the point, the Prudential, which is the single largest private health insurer in the country, has only 4% of the private health insurance market, and that is spread over 50 states. We are too dispersed to negotiate individually and we are prohibited by antitrust laws from negotiating jointly.

Experience validates our frustrations over cost shifting. Experience has also shown that second-opinion surgery, ambulatory benefits and other coverage designed to reduce utilization are successful but alone have limited impact. Finally, experience with State prospective payment systems demonstrates their effectiveness in containing aggregate health care costs.

This is a developing area and no one yet can claim to have all the answers to the questions of a single hospital payment reform system. In fact, two of the oldest and most effective systems, the Maryland and New Jersey programs, operate quite differently. HHS recently granted waivers to New York and Massachusetts, two of the nation's high cost states. In both of these states, all parties with a direct stake in hospital payment change--providers, employers, unions and insurers--actively participated in designing a solution. Both are implementing approaches different from those in Maryland and New Jersey. We believe all of these different approaches will lower costs and produce useful comparisons.

Maine and West Virginia have also recently enacted all-payer programs which we hope will meet the new criteria for Medicare recognition.

The federal government's past role as a catalyst has helped encourage variety and innovation. We believe this is the prime role for the federal government, and should be continued. We applaud and commend the Congress for its recognition of qualified state programs as an alternative method of Medicare payment under the Social Security Amendments of 1983. We urge you now to adopt positive incentives to States to develop their own qualified programs for all patients.

One such incentive would be a Medicaid reward for those States which enact qualified programs similar to the reward in present law for States which had hospital cost containment programs in place on July 1, 1981. A modest Medicaid reward would be most appropriate for those States which are moving ahead to help solve a national problem-health cost inflation. It would be a fitting way to attack a national problem at the State level without a new Federal bureaucracy. It would be a fitting reward to those States which, by holding down rising health costs, are taking action to hold down the number of citizens forced into Medicaid and other public assistance programs by health care inflation. Such a proposal need not, in fact, should not, require the States to set-up hospital rate setting commissions. It need not, and should not, require any particular type of program, rate-setting, DRG, or otherwise, as long as the State program meets the criteria set forth in the Social Security Amendments of 1983.

We further urge the Congress to take the next step on prospective pricing - to enact legislation extending a hospital prospective pricing system to all payers, not just Medicare, to take effect four years after enactment in any State which has not enacted a qualified State program. Such legislation would give every State time to enact legislation suitable to its own particular

needs and yet guarantee that all our citizens get the protection they deserve. It would also provide a stimulus to those who believe our problems are best solved at the State level to move ahead and get the job done so there will be no need for a Federal all-payer program.

We also recognize that any over-all solution to the problem of rising health costs requires a reconciliation of the vital interests of a number of important segments of our society. Therefore we continue to support the appointment of a Presidential Commission, upon which all of these interests, providers, insurers, employers, and unions, among others, can be represented and which can be charged with the constructive resolution of the conflicts which make this problem so intractable.

Mr. Chairman, the health insurance business shares your strong commitment to cost containment. There is more we would like to do ourselves. Nevertheless, we find that we must struggle under some formidable handicaps. The field on which we compete is strewn with regulatory and economic obstacles that significantly interfere both with our ability to serve our customers and with efforts to improve the efficiency of the health care financing and delivery system as a whole.

Put another way, what would the insurance industry like to do and what are the barriers to their doing it?

Let us first identify these handicaps, all of which are externally imposed upon us. Then we will return to a discussion of each of them. Unlike the noninsured plans with which we compete, we are subject to stringent state

regulation. Our product design creativety is also stifled by a range of provider protection laws. Unlike our chief competitors in many instances, we pay state premium taxes and federal income taxes on the earnings on our reserves. In addition, the highly competitive nature of our business and the antitrust laws preclude us from collaborating effectively for cost containment purposes.

If the efficiency of our health care system is ever going to be improved through more meaningful patient participation, we must first make certain that the choices available to consumers are not economically biased because of governmental constraints. When individuals or employers choose a third party payment mechanism, the choice should be among realistic alternatives. This is not fully possible today.

What we would like to see is a "level playing field" for all third party payors, including Medicare and Medicaid. When Medicare pays less, private payors pay more--in effect constituting a hidden tax on non-government patients which is expected to be $8.8 billion in 1984.

This cost shift severely impedes the ability of private payors to compete with government programs under Medicare voucher system such as that proposed by the Administration.

We want Medicare to pay on the same basis as other payors. The provision in the recently-enacted Social Security Amendments providing for Medicare recognition of qualified state hospital payment programs is a major step in the right direction.

Another possibility would be to require Medicare-approved hospitals to allocate equally among all private patients that portion of their budgets not reimbursed by Medicare or Medicaid.

Second, as with the Medicare cost shift, state regulation does not apply evenly to various classes of payors. Employers that self-insure employee welfare benefit plans are exempted from state regulation by the preemption clause in Section 514(c) of ERISA. Such noninsured plans are not subject to the myriad legislative and regulatory requirements imposed upon insured plans. These requirements, which vary considerably from state to state, typically include a wide range of mandated benefits, free choice of provider provisions, and continuation of coverage and conversion options which are often quite costly. Employers may avoid these obligations as well as the necessity of maintaining reserves and paying premium taxes simply by not insuring their plans.

In order to nurture competition in the health care field, we should assure that all competitors are subject to the same rules.

Insurance laws and regulations serve a beneficial purpose in protecting the insured public. However, ERISA now precludes the states from regulating the affairs of noninsured health plans, but at the same time the federal government has failed to regulate these health plans.

It is also a very real impediment to innovative plan design by insurers.

We are not proposing a substitution of federal for state regulation. However, our business does support, for example, Section 3605(a)(ii)(I) of S.1541 (the Retirement Income Incentives and Administrative Simplification Act, introduced by Senator Nickles) which would amend ERISA to preempt state mandated benefit laws for insured as well as for non-insured employee benefit plans. This simple change would be a first step along the way to more equitable competition and more rational benefit design.

We would like to set up programs in every state, as we have done in Connecticut, to guarantee the availability of health insurance to all individuals. However, again, ERISA is a major barrier to our seeking state laws setting up these programs. We feel strongly that all competitors in the employee health benefit market should share proportionately in any program losses. However, ERISA preempts state laws to the extent those laws require self-insured plans to participate in these state programs. Thus, self-insured plans are effectively shielded from the economic burden of the guaranteed availability programs, a burden which falls on an ever-decreasing base caused by existing legal barriers to equitable competition. The program could be solved either by an amendment to ERISA or by legislation authorizing insurers to set up such pools and requiring all employee health benefit plan funding mechanisms to participate in such a pool as a condition of income tax deductibility or by otherwise requiring self-insured employers to participate in such programs.

Last, we would like to share data and engage in joint cost containment activities, such as negotiating with health providers, the development of

physician profiles and patterns of care, and other such activities. Specifically:

1. Insurers should be authorized jointly to collect, analyze and use information on the quality, cost, or utilization of health care services, including the development of reasonable, or preferred utilization practices as guides for insurance reimbursements to providers. In other words, commercial insurers should be able to join together to assemble data.

2. Insurers should also be empowered collectively to negotiate with health care providers to develop utilization standards. It should further be possible for insurers jointly to contract with review organizations to provide peer review and concurrent hospital review for private patients and to provide data to such organizations.

For that reason the Health Insurance Association strongly supports S. 2051, introduced by Senator Arlen Specter.

Senator Specter's bill will, for the first time, allow insurance companies to cooperate in collecting, sharing and using important health care data to analyze costs and quality. That data, in turn, can be given to consumers and employers, thus helping them make more educated health care decisions. And finally, the bill will give those who pay for hospital care the ability to join together to negotiate for better rates and care without violating federal law.

Most significantly, the bill satisfies two important criteria in the nation's fight to control rising costs: First, it creates competition among hospitals, and second, it is a private sector initiative requiring no taxes, no government intervention and no additional burden to patients, consumers or employers.

Employee Health Tax

On the other side of the cost containment coin, Mr. Chairman, the Administration has asked Congress to levy a tax on employee health plans as part of its F.Y. 1985 legislative program.

The health insurance industry opposes this proposal as discriminatory, unfair, and one that will do nothing to stop health-care-cost inflation, nor will it raise the revenue suggested as labor-management negotiations rearrange the employee benefit package.

Among the arguments against such a tax are a following:

* It penalizes older workers. Elderly groups tend to use health care more frequently than younger, healthier workers. Hence, the cost of health insurance for a group which includes more than the average number of older workers not only will be higher but could discourage many employers from hiring the older worker. Under the Administration porposal, these groups will be adversely affected by a cap, while younger groups with similar coverage may not be taxed.

* It penalizes those in hazardous, high-risk occupations. Some groups, such as iron workers or coal miners, are usually considered a higher "risk," and are typically charged higher health insurane premiums. These groups could be unfairly taxed while otner groups with similar coverage--such as clerical workers--would be unaffected.

* It is a form of "double taxation." The Health Insurance Association of America estimates that Medicare and Medicaid payment practices will result in $8.8 billion being shifted to patients covered by private health insurance in 1984 to make up for government underpayments to hospitals. For the government to shift these costs to the private sector and then put a tax on the resulting higher insurance premiums is patently unfair.

* It unfairly affects certain geographic areas. The cost of health care is higher in some areas, such as large metropolitan cities. A single national tax cap does not take geographic differences into account, and thus would particularly penalize those in high-cost areas. Conversely, it would allow the tax-free purchase of much more generous benefit plans by those in low-cost areas.

* It could result in reduced coverage for preventive care services. As employees scramble to reduce their overall premium rates, essential preventive care services such as dental care, vision care, mental health benefits, and alcohol and drug abuse services may be dropped from benefit plans. Dropping these benefits does nothing to reduce hospital costs, and in the end may have the opposite effect.

Mr. Chairman, all of those in the private sector who have the most to gain from effective hospital cost containment - the employers, the unions, the insurers - in essence, all of those in the private sector on the paying side of the equation - say the employee health tax will be ineffective in curoing rising costs and are opposed to its enactment.

It is a fact that the medical expense people fear most is hospital expense, and it is hospitalization insurance that will be the last, and least, effected by this proposal.

The most sensible approach to keeping hospital costs under control is prospective payment reform that applies to all patients, not just Medicare patients. Rising costs are not just a Medicare-Medicaid problem but a national health care problem as well. A prospective all-patients system will force cost-saving incentives into the structure of hospital payments and operations and will have many times the impact of the band-aid approach of taxing workers' health insurance premiums.

We are beginning to see that prospective payment systems that include all-payers, including Medicare, now in place in four states, can work. There is no reason why the Congress should try the untested theory of taxing health insurance premiums--and every reason why it should not.

In summary, the health insurance business shares with this committee a strong committment to cost containment. It is a strong supporter of state

prospective pricing systems which meet the criteria laid down in the Social Security Amendments of 1983.

We do not believe the Congress should mandate any particular kind of system, either rate review or DRG or any other, to the states in order to have a qualified program.

The HIAA does feel, however, that positive incentives should be enacted by the Congress to encourage the states to develop their own qualified programs. This could take the form of a Medicaid reward for enacting a program meeting the standards established in the Social Security Amendments of 1983.

We would also support Federal legislation which would give the state four years to act, after which the Federal prospective pricing system would apply in any State which had not enacted its own qualified program.

Clearly these ideas coincide with some of the concepts expressed in S. 2424, introduced by Senator Kennedy, and H.R. 4870, introduced by Congressman Gephardt. To that extent we agree with the sponsors of that bill and applaud the initiative they have taken. All our citizens need relief from rising hospital costs, not just Medicare.

We appreciate this opportunity to present our views. We will certainly be glad to work with the committee for constructive solutions to the difficult proolems facing us all with the rising cost of health care.

QUESTIONS SUBMITTED BY SENATOR ORRIN G. HATCH FOR MR. DONALD PETERSON

Question No. 1 Submitted by Senator Hatch

Is additional legislation necessary to assist private industry in developing competitive health care plans?

Answer:

Yes. What we would like to see is a "level playing field" for all third party payors, including Medicare and Medicaid. When Medicare pays less, private payors pay more--in effect constituting a hidden tax on non-government patients which is expected to be $8.8 billion in 1984. When that hidden tax does not fall equitably on all competitors, fair competition is impossible.

This cost shift severely impedes the ability of private payors to compete with government programs under Medicare voucher system such as that proposed by the Administration.

Medicare should pay on the same basis as other payors, through Federally-qualified State all-payor programs. The provision in the recently-enacted Social Security Amendments providing for Medicare recognition of qualified state hospital payment programs is a major step in the right direction.

We urge the Congress to take the next step on prospective pricing - to enact legislation extending a hospital prospective pricing system to all payers, not just Medicare, to take effect four years after enactment in any State which has not enacted a qualified State program. Such legislation would give every State time to enact legislation suitable to its own particular needs and yet guarantee that all our citizens get the protection they deserve.

Congress should also enact a Medicaid reward for those States which enact qualified programs similar to the reward in present law for States which had hospital cost containment programs in place on July 1, 1981. It would be a fitting way to attack a national problem at the State level without a new Federal bureaucracy. Such a proposal need not, in fact, should not, require the States to set-up hospital rate-setting commissions. It need not, and should not, require any particular type of program, rate-setting, DRG, or otherwise, as long as the State program meets the criteria set forth in the Social Security Amendments of 1983.

Another possibility would be to require Medicare-approved hospitals to allocate equally among all private patients that portion of their budgets not reimbursed by Medicare or Medicaid.

Second, as with the Medicare cost shift, state regulation does not apply evenly to various classes of payors. Employers that self-insure employee welfare benefit plans are exempted from state regulation by the preemption clause in Section 514(c) of ERISA. Such noninsured plans are not subject to the myriad legislative and regulatory requirements imposed upon insured plans. These requirements, which vary considerably from state to state, typically include a wide range of mandated benefits, free choice of provider provisions, and continuation of coverage and conversion options which are often quite costly. Employers may avoid these obligations as well as the necessity of maintaining reserves and paying premium taxes simply by not insuring their plans.

In order to nurture competition in the health care field, we should assure that all competitors are subject to the same rules.

State taxation and regulation should apply equally to all funding mechanisms. We do not propose a substitution of federal for state regulation. However, the insurance industry does support Section 3605(a)(ii)(I) of S.1541 (the Retirement Income Incentives and Administrative Simplification Act, introduced by Senator Nickles) which would amend ERISA to preempt state mandated benefit laws for insured as well as for non-insured employee benefit plans. This simple change would be a first step along the way to more equitable competition and more rational benefit design.

We would like to set up programs in every state, as we have done in Connecticut, to guarantee the availability of health insurance to all individuals. However, again, ERISA is a major barrier to our seeking state laws setting up these programs. We feel strongly that all competitors in the employee health benefit market should share proportionately in any program losses. However, ERISA preempts state laws to the extent those laws require self-insured plans to participate in these state programs. Thus, self-insured plans are effectively shielded from the economic burden of the guaranteed availability programs, a burden which falls on an ever-decreasing base caused by existing legal barriers to equitable competition. The program could be solved either by an amendment to ERISA or by legislation authorizing insurers to set up such pools and requiring all employee health benefit plan funding mechanisms to participate in such a pool as a condition of income tax deductibility or by otherwise requiring self-insured employers to participate in such programs.

We would like to share data and engage in joint cost containment activities, such as negotiating with health providers, the development of physician profiles and patterns of care, and other such activities. Specifically:

1. Insurers should be authorized jointly to collect, analyze and use information on the quality, cost, or utilization of health care services, including the development of reasonable, or preferred utilization practices as guides for insurance reimbursements to providers. In other words, commercial insurers should be able to join together to assemble data.

2. Insurers should also be empowered collectively to negotiate with health care providers to develop utilization standards. It should further be possible for insurers jointly to contract with review organizations to provide peer review and concurrent hospital review for private patients and to provide data to such organizations.

For that reason the Health Insurance Association strongly supports S. 2051, introduced by Senator Arlen Specter.

Senator Specter's bill will, for the first time, allow insurance companies to cooperate in collecting, sharing and using important health care data to analyze costs and quality. That data, in turn, can be given to consumers and employers, thus helping them make more educated health care decisions. And finally, the bill will give those who pay for hospital care the ability to join together to negotiate for better rates and care without violating federal law.

Most significantly, the bill satisfies two important criteria in the nation's fight to control rising costs: First, it enhances competition among hospitals, and second, it is a private sector initiative requiring no taxes, no government intervention and no additional burden to patients, consumers or employers.

Question No. 2 Submitted by Senator Hatch

What effects would a tax cap on employee health plans have in reducing health costs or increasing competition? Do you anticipate any drawbacks to this type of approach?

Answer:

A tax cap on employee health plans has very serious drawbacks and may well act to increase, not reduce, rising hospital costs. The health insurance industry opposes this proposal as both poor health policy and poor tax policy. Furthermore, a recent independent study by Price Waterhouse raises serious questions about the assumptions upon which the claimed revenue gains are based.

The proposal would result in reduced coverage for preventive care services. To the extent the tax causes plans to reduce benefits, we expect preventive care services such as dental care, vision care, mental health benefits, and alcohol and drug abuse services to be dropped before hospital coverages are reduced. Dropping these benefits does nothing to reduce hospital costs, and in the end may increase them.

Several recent studies confirm these conclusions. The Rand Corporation study on health care costs published in November 1982 stated that, while the increased cost of employee health insurance resulting from the tax would reduce the over-all amount of health protection available, "Dental care, ambulatory care, drugs, and similar services would probably become uncovered ... hospital insurance would probably be least changed." Yet it is hospital costs, which constitute more than two-thirds of Medicare's expenses, which are the major problem.

The Rand study also points out that while taxing employees could reduce hospital utilization, the hospitals could recoup the major portion of any lost revenues by raising prices charged the remaining patients. The study concludes, "Effects on consumers' health status are as yet unknown."

A 1983 paper by Gail Wilensky of the National Center for Health Services Research, also concludes that "the proposed change in tax policy will have little effect on expenditures for hospital care, routine physician visits," etc.

Studies and data presented to the Senate Finance Committee in June 1983 by the Employee Benefit Research Insitute are also pertinent. Contrary to the conventional belief that employer plans have simply absorbed the inflation in health care costs, their paper states that real employer contributions to health insurance as a share of compensation fell at an annual rate of nearly 8 percent.

EBRI also points out that "Among households that would be affected ... the tax burden would be severely regressive. As a proportion of income, persons at the lowest level of income (those reporting less than $10,000) would pay more than six times the amount of the additional tax than would persons with income over $50,000."

In studying the impact on the rate of health insurance coverage, the study concludes "Current tax policy probably raises private coverage rates significantly among lower-income worker households, households with fragmented employment histories, younger households, and both single-person and single-parent households."

The proposed health tax would penalize older workers. Older workers tend to use health care more frequently than younger, healthier workers. Hence, older workers, and groups including older workers, will pay more tax. This also gives employers an incentive to avoid hiring older workers.

It penalizes those in hazardous, high-risk occupations. Some groups, such as iron workers or coal miners, are usually considered a higher "risk," and are typically charged higher health insurance premiums. Those groups with higher health costs would be taxed while other groups with similar coverage--such as clerical workers--would be unaffected. If all plan benefits were reduced to fit a uniform national dollar ceiling, those who need health insurance the most would get the least.

The proposal is an unfair form of "double taxation." We estimate that Medicare and Medicaid payment practices will result in $8.8 billion being shifted to patients covered by private health insurance in 1984. For the government to shift these costs to the private sector and then put a tax on the resulting higher insurance premiums is patently unfair.

The proposal unfairly affects certain geographic areas. The cost of health care is higher in some areas, such as large metropolitan cities. A single national tax cap does not take geographic differences into account, and thus would particularly penalize those in high-cost areas. Conversely, it would allow the tax-free purchase of much more generous benefit plans by those in low-cost areas.

The Martin E. Segal Co. in September 1983 concluded a study of 650 multiemployer health plan clients with more than 562,000 workers covered by affected health plans. It showed wide variations. On average, each employee would pay an extra tax of $144 the first year, but some groups would pay almost $500. Workers in the midwest had the highest average tax increase, $163; the south had the lowest, $101. Extra tax for workers in the transportation industry averaged $157; in the publishing industry, $62.

In summary, a new tax on employees for employer-paid health plans would be discriminatory, unfair, and ineffective as a means of slowing the rising cost of hospitalization in that it:

1. penalizes older workers, who have higher health costs;

2. penalizes those in hazardous, high-risk occupations who have higher health costs;

3. penalizes women, who have higher health costs;

4. unfairly affects certain geographic areas where health costs are higher;

5. unfairly affects small businesses which have higher premium costs;

6. will add substantial administrative and regulatory burdens on all businesses, particularly those which self-insure;

7. constitutes a form of double taxation to the extent that Medicare costs are already being shifted to non-government hospital patients and are reflected in higher premiums;

8. would result in reduced insurance coverage for preventive services, dental care, vision care, treatment of mental illness, alcoholism, and drug abuse;

9. could result in less continuation of coverage for laid-off workers;

10. will adversely effect low-income and marginal workers more than high-income workers, and

11. discourages the growth of HMOs, a proven competitor in the health care fields.

QUESTIONS SUBMITTED BY SENATOR GRASSLEY FOR MR. DONALD M. PETERSON

1. How do you respond to the argument of Mr. Markson from Blue Cross to the effect that an all-payer system doesn't eliminate charge shifting, but just institutionalizes it?

Answer: Mr. Markson's remark confuses the issues of financing care for the poor and costshifting among payers. All-payer systems do not eliminate that costshifting which enables hospitals to recover the costs of charity care from other payors. But without such costshifting, the indigent would be forced to go without treatment or a new tax financed aid program would have to be created. All-payer systems do eliminate the costshifting between payers so that all paying patients pick up their fair share of costs, including a portion of the costs for nonpaying patients.

All-payer systems don't institutionalize current costshifting; rather, they equalize charges so that payers that pay less truly cost less and those costs otherwise not covered by any payer, such as charity care, are equally covered by all payers.

Senator QUAYLE. Thank you, Mr. Peterson.

Mr. Markson, I wonder if you might be able to comment on the advancement of HMO's and PPA's in the different States, States which are market oriented versus those which have the all-payer rate. In other words, which States have you seen an increase in this type of competitive practices and we can get to a comparison of the all-payer States versus the competitive States.

Mr. MARKSON. Senator, I am most familiar with the Greater Philadelphia area and with the State of Pennsylvania which does not have the State mandated all-payers system. In the State of Pennsylvania, there has been a tremendous expansion of HMO's, PPO's. This has been particularly true in the Greater Philadelphia area.

In addition to those alternative methods of delivery of care, a variety of new alternative methods have developed in the past year or two and have been implemented. There are several others awaiting approval from the State insurance commissioner as well as many on the drawing boards. We are experiencing more than ever before customers coming to us, providers of care coming to us and asking to develop new, innovative, experimental methods where quality care can be delivered at a lower cost.

Senator QUAYLE. Do you have any breakdown, then, as to how these particular plans would flourish in States?

Mr. MARKSON. I believe that Jack Meyer's book, which we are furnishing to the committee, outlines in some detail how rate regulation has served to stifle innovation and cost containment at the same time it has failed to reduce the rate of utilization of health care services. Beyond that, Senator, I don't have it broken down by classes of all-payers versus unregulated States.

Senator QUAYLE. OK.

Mr. Peterson, are there a couple obstacles that you can identify before you go to the all-payers system that you really need relief in to get that level playing field that you referred to? Are there a couple intermediary steps that might be taken before we take the other foot or contemplate taking the other foot with an all-payers proposal?

Mr. PETERSON. I think a number of attempts have been made in the past to curtail the inflation that we have seen in health care costs, but none thus far have really given any sign that they are going to be successful. We are operating now, for all intents and purposes, on a cost plus basis, and until we get to a system that really rewards efficiency on the part of the providers, I just don't see how the battle can be won. Naturally, from our standpoint, we are looking for that level playing field.

I would hate to be the very last person who has an individual policy after everyone else has negotiated his preferred provider arrangement, and that one single individual then is responsible for medical education, bad debts, the television sets, and everything else that the negotiated providers have been able to push out of their domain.

Senator QUAYLE. What in effect you are asking is that you really at a point just before you have to have the Government come in and provide that level playing field for the providers is the essence of what you are saying. Am I correct?

Mr. PETERSON. Well, the level playing field is not necessarily for the providers but a level playing field for the third party representatives. Let's put it that way.

Senator QUAYLE. In other words, you would like to have more regulation. I suppose eventually if you extend the thought of regulation you would have regulation in getting the level playing field for purchasers as well.

Mr. PETERSON. Yes. Most definitely. Negotiated rates should not just be based on clout and muscle, really. It should be based on demonstrated efficiencies. We are willing to recognize that there can and will be demonstrated efficiencies, but not just on sheer muscle, no.

Senator QUAYLE. Are there any potential obstacles that you see as they would be imposing more regulations on the insurance companies as well as they do on providers? If we are going to have this level playing field, I suppose that some will say that we are going to have it for all. I guess you are willing to accept that from the Federal level.

Mr. PETERSON. We have learned to live with regulation, and lots of it, from 50 different States for years, and I think we can live with it in the future if it provides, one, an opportunity for fair competition, and two, and probably more importantly at this point in time, something that has to be done to curtail the health cost escalation that we have seen. We have to reduce the cost of delivering the care, and the only way it can be done, from my standpoint, is by rewarding efficiency and getting off a cost plus approach.

Senator QUAYLE. Rewarding efficiency is an essential ingredient of competition. That is what we are all for.

Mr. Markson, do you think this all-payers system would create more competition?

Mr. MARKSON. No, Senator. I think it would completely stifle innovation in the cost containment field by removing the incentives to invent a better mousetrap. We believe that while it is important to concentrate on cost, the true savings come from changing the behavior of the system to effect utilization. In a nonregulated environment or a regulated environment that doesn't have an all-payers system, the growth of alternatives to in-patient care as a substitute has grown dramatically. In the Greater Philadelphia area, use of ambulatory surgery over a 3-year period increased 200 percent as a substitute for in-patient hospitalization. This has produced savings in the Greater Philadelphia area in total of approximately $83 million in just 1983 and has produced the favorable result that is shown on that chart which is reproduced in the materials we have left with you.

Senator QUAYLE. OK.

Gentlemen, thank you very much.

Next we have Mr. McMahon, Mr. Bromberg, and Mr. Schenken. Mr. McMahon, you may proceed.

STATEMENT OF J. ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, CHICAGO, IL

Mr. MCMAHON. Thank you, Mr. Chairman.

I am Alex McMahon, president of the American Hospital Association. I have a full statement to submit for the record and will make some summary comments.

The American Hospital Association is very pleased to have this opportunity to bring testimony to a hearing on strategies to reduce the rate of increase of hospital costs and to report on some very favorable cost trends, first, and then to explain why hospital costs are changing so dramatically.

In short, Mr. Chairman, to anticipate later comments, they are changing in response to new incentives, not to regulation. More regulation, as proposed by Senator Kennedy and Representative Gephardt, would, as you have heard from some of the other witnesses, freeze a system undergoing substantial movement toward quality care with a reasonable rate of increase.

Congressman Gephardt, incidentally, mentioned the failure of the voluntary effort. He was very helpful in that. He and I should have realized, in retrospect, it was doomed to fail because it didn't have the right kinds of incentives in it. We were asking people, hospitals and doctors, to run directly against the economic incentives in the then current payment system.

First, Mr. Chairman, let me describe what is happening to hospital costs. Total hospital cost increases, which were 15.8 percent in 1982, dropped to 10.2 percent in 1983. If you look at in-patient costs, the thing that we most focus on, it dropped from 15.6 percent in 1982 to 9.6 in 1983. In the first quarter of 1984 over the first quarter of 1983, it is down to 5.6 percent.

Mr. Chairman, we have never seen as dramatic a drop in the rate of increase, and I suggest to you it has to do with the incentives.

Let me pause just for one additional comment, what is happening is happening, obviously, across the board without cost shifting. You heard some testimony to the contrary, but I am talking about total costs, not medicare. Therefore, there can't be any cost shifting because that is the kind of rate of increase we are getting for medicare.

On pages 3 to 5 of my testimony, I have noted some of the efficiencies, but I have also noted there, even more importantly, that admissions are down, particularly under 65, and the length of stay is down, both under 65 and in the medicare population.

Why is this? We think it comes very clearly from the new incentives for hospitals, both in TEFRA and in DRG on the Federal side and in some of the initiatives that you have heard testimony on this morning and early this afternoon on the private side. The medicare initiatives, Mr. Chairman, are spilling over to others. There is no cost shifting that we can identify.

The incentives in the private sector, the changing of benefit packages, of employee choice, and of cost sharing, and others are obviously providing incentives to doctors and hospitals to respond appropriately. The provider response is clearly in innovations of vertical integration and other kinds of systems. And that is important, too, because, as I said earlier, Mr. Chairman, more regulation could freeze the system moving in the right direction.

Services are being moved around. We are seeing changes from in-patient to ambulatory care on the one side and home health care

on the other. To attempt to control one part of a dynamic system, Mr. Chairman, would be disruptive. It could be anticompetitive because it is going to keep things the way they are instead of moving services through a vertically integrated system.

There are still some problems. In the testimony, on pages 7 and 8, we talked about the care of the poor. On pages 8 and 9, on the implications of new technology and what is going on. But I am not hearing any complaints now about the inability of hospitals to adapt some of the new technological developments, because there is enough efficiency going on so that there is room under the system that we have.

Senator Kennedy, at one point, asked a question if DRG's are good for medicare, and they are, why aren't they good for the rest of the population? The answer is very clear. DRG's were based on the experience of an elderly population, not an across-the-board population. There are differences, as we know from our statistics.

Now, the DRG price differences present a problem, too, and we have touched on that but we are working with the administration on that. Some of the problems we have are both patient mix and the geographical differences, but we are working on that.

In sum, Mr. Chairman, as we look for the future, we are convinced that we must rely on innovation and the responses to these new incentives, but not to regulation. Incentives and marketplace responses are working, and it is a good time, Mr. Chairman, to change that old saw around, this is the time not to do something, just stand there.

[The prepared statement of Mr. McMahon and responses to questions submitted by Senators Hatch, Kennedy, and Grassley follow:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE LABOR AND HUMAN RESOURCES COMMITTEE
ON HEALTH CARE COSTS AND SOLUTIONS
June 21, 1984

Mr. Chairman, I am J. Alexander McMahon, President of the American Hospital Association (AHA). The AHA, which represents over 6,100 member hospitals and health care institutions, as well as more than 38,000 personal members, is pleased to have this opportunity to present its views on health care cost issues to the Senate Labor and Human Resources Committee.

INTRODUCTION

I am particularly pleased to be here today, as this hearing provides an opportunity to report on the substantial progress the hospital industry has made in reducing the rate of increase in hospital costs over the past year. This hearing is also an appropriate forum to discuss significant changes that are occurring in the hospital industry in response to shifting demands by both public and private payers. These changes should ensure that hospital costs are, as much as is possible, brought into line with consumer needs and expectations. Legislation recently introduced by Senator Quayle, S.2501 and

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S.2502, build on this market oriented approach. In contrast, bills introduced earlier this year by Senator Kennedy and Representative Gephardt would revert to intensive regulation as a cost-containment mechanism rather than rely on both provider and consumer incentives.

For several years the American Hospital Association has advocated the use of incentives to bring about hospital cost containment. The incentives-based approach stimulates the industry to develop new ways of delivering services at lower cost, and encourages hospital managers to be responsive to both consumer and payer demands. The private sector has adopted elements of this approach, with substantial activity occurring in the development of private sector prospective pricing systems, preferred provider organizations and selective provider contracting, and innovative health insurance packages. Medicare's prospective pricing system provides an example of how powerful the incentives approach can be when adopted by a major payer. In addition, it provides an illustration of the issues that must be resolved if the incentives-based approach is to be successful.

The AHA continues to believe that the incentives approach is a better way to control costs than is regulation. Regulation will discourage innovation that is essential if high-quality health care is to be made available at a cost that the public is willing and able to pay. Regulatory approaches, particularly when applied across the board, inhibit the ability of providers to respond to the unique needs and expectations of specific consumer groups and employers.

1983 PERFORMANCE

The recent performance of the hospital industry offers substantial evidence that incentives are bringing about a major change in the cost picture. For example, the rate of increase in total hospital expenses slowed from 15.8 percent in 1982 to 10.2 percent in 1983. The reduction in the rate of increase in inpatient expenses has been even greater: from 15.6 percent in 1982 to 9.6 percent in 1983. Early data for 1984 indicate an even more dramatic change: the annualized rate of increase in total expenses for the first three months of the year was only 5.6 percent. This substantial reduction cannot be attributed solely to demand or marketbasket pressures. As trends in hospital employment and length of stay indicate, a substantial part of the industry's performance in 1983 is due to improvements in hospital efficiency in both the production and use of hospital services.

During the past several years, a trend toward slower growth of hospital employment has been established. The increase in hospital employment was dramatically lower in 1983 than in 1982. Total employment rose just 1.4 percent in 1983 compared to a 3.7-percent increase in 1982. The increase in staffing ratios also was smaller in 1983 than in 1982, indicating that slower growth of employment was not entirely due to slower demand growth. As with total expenses, the first months of 1984 show an even more striking pattern.

Total hospital employment actually declined during the first quarter of the year. This reduction, made possible in part by higher productivity, also reflected a decrease in the growth rate of the volume of services provided by hospitals.

Slower growth in the volume of hospital services has contributed to the moderation of hospital expense trends. Total admissions declined 1/2 of 1 percent during 1983, after remaining stable in 1982. Admissions of patients 65 years of age and older increased 4.7 percent during 1983, slightly below the historical trend. Length of stay for patients 65 years of age and older was down sharply--4.5 percent--resulting in almost no net increase in total patient days in this category. These annual trends were even more apparent in the fourth quarter of 1983, with admissions of patients 65 years of age and older increasing by less than 1 percent, while the average length of stay for these patients fell 5.5 percent. In the first quarter of 1984, admissions of patients over the age of 65 actually declined 1.5 percent, compared to the same period of 1983, while the length of stay for patients over the age of 65 declined 6.9 percent.

Slower utilization growth was not limited to the over-65 population. Admissions for patients under the age of 65 were down sharply during 1983--2.8 percent--continuing trends established in 1982. The early months of 1984 are consistent with these slower growth trends.

The significance of these trends is readily apparent. First, hospitals are responding to incentives created by both prospective pricing and the system of per-case payment established by the Tax Equity and Fiscal Responsibility Act.

Medicare length of stay is down, the increase in hospital staffing levels is slowing, and the overall increase in hospital costs is moderating.

Second, because real changes are occurring in hospital performance, savings are being generated not only for the Medicare program but also for other payers. This has been achieved without a monolithic system of payment covering all third parties and patients, and without a burdensome regulatory apparatus. It is critical that hospitals have the opportunity to continue their response to the incentives created by prospective pricing and that the system not be manipulated to produce arbitrary, short-term reductions in federal outlays.

Finally, these changes have occurred with little change in the consumer incentives established by Medicare, although changes in the benefit design of commercial insurance have increased consumer cost-consciousness. As is being demonstrated in the private sector, and as is recognized in the Quayle bills, consumer incentives and innovative design of delivery systems--without extensive regulatory control--can make a substantial contribution to the solution of the cost problem.

PRIVATE SECTOR DEVELOPMENTS

Although Medicare prospective pricing overshadows all other developments facing the hospital industry, those other changes are having a significant

impact as well. Possibly the most widely discussed new concept in health care delivery is that of preferred provider organizations (PPOs). A survey conducted by the American Hospital Association and sponsored by the Health West Foundation in late 1982 and early 1983 identified 84 hospitals involved in preferred provider organizations and more than 700 hospitals that were considering such affiliations. A follow-up survey conducted in July 1983 identified 40 operational PPOs, most of which involved two or more hospitals. The key characteristic of these organizations is their use of unique combinations of health care delivery alternatives to meet the particular needs and demands of an employee group. Both the services covered and the way of delivering those services vary from plan to plan, which ensures a high degree of responsiveness to the needs of the particular groups involved.

The development of preferred provider organizations and other innovative competitive plans will require several years. Most state insurance laws were designed with conventional health insurance in mind, but as states see the potential benefit of new, innovative plans to their citizens, old laws will need revision. Such revision is best accomplished on a state-by-state basis. State laws, for example, protect consumers against insurance plan insolvency by establishing minimum financial requirements and against misrepresentation of benefits. Changes in these laws must be made only after careful study and evaluation of alternative protections.

With increased emphasis on health care costs, many employers are re-examining their health insurance coverage to explore alternative ways of providing

financial protection to their employees while encouraging the cost-effective use of hospital and other health care services. Employers also have shown substantial interest in the PPO concept. Many are actively developing PPOs as an alternative to conventional health insurance. In addition, employer/provider coalitions continue to be a promising means of bringing about the effective collaboration of providers, employers, and organized labor to contain health care costs. And, the Community Programs for Affordable Health Care project, sponsored by the Robert Wood Johnson Foundation, is stimulating innovative efforts to develop local health care financing and delivery systems that are responsive to community needs and resources.

LONG-TERM ISSUES

The above mentioned 1983 trends clearly indicate that hospitals are responding to new incentives. It is important to recognize, however, that financing systems have purposes other than simply containing costs, and that the rate of cost increase is not the only health policy issue at hand. Among the most important of these issues are access to care by the uninsured and the management of technology.

Though it sounds simplistic, access to care is governed by the fact that there is no such thing as "free care." Hospitals must pay for supplies, medicine, and labor, regardless of their patients' ability to pay. An effective pricing

policy for health care must take into account these costs of doing business and providing for the health care needs of all patients in a community. As private payers and government assume responsibility for the cost of services used by their enrolled population, the prices paid must reflect the losses incurred as a result of the communities' providing for access to care by all segments of the community. One would expect that a retail store would include in its pricing structure the losses incurred by breakage, spoilage, pilferage, and bad debts. Hospitals are no different. The problems they experience are greatly exacerbated by reductions in Medicaid payment levels and by limits on Medicaid eligibility and benefits. If these reductions continue, a hospital will reach a point when it no longer can charge a competitive price to other purchasers of hospital care. A solution to this problem lies in the development of a more adequate program for meeting the health care needs of the uninsured population.

Another issue that will continue to attract public attention is the appropriate management of technology. In recent years, it has become popular to propose the financing of technological advances through improved productivity. Although the original prospective pricing legislation provided for a 1-percent technology factor in the marketbasket formula used to set prospective prices, this adjustment has become a target of federal budget balancers and may be lost to hospitals. Although important, budgetary issues should not be allowed to dominate the formulation of health policy by the federal government, state government, or the private sector. It is

unrealistic to expect that improvements in efficiency can be used to fund technological advances. Efforts to do so inevitably result in significant shortfalls in the services available to both public and private patients.

It must be kept in mind that technological advances can decrease as well as increase costs. Many technological advances increase demand for care because they enhance the ability of medicine to treat illness and extend the quality and length of life. Since the enactment of the Medicare program, there has been a steady increase in the life expectancy of the elderly that has tended to parallel the increase in Medicare costs. The U.S. Office of Technology Assessment has identified neonatal intensive care as a technological advance that has improved the chances of survival for premature and high-risk infants. Similarly, five-year survival rates for childhood leukemia victims have improved tremendously in recent years. In examining hospital departmental staffing trends, we find that the fastest growing departments have been those using more advanced technology and higher-paid therapeutic and diagnostic services. Providing these services raises total costs, but at the same time improves patient outcomes and health status, resulting in long-term savings in health outlays.

The implementation of the Medicare prospective pricing system provides a unique opportunity to examine the relationship among the objectives of cost-containment, quality of care, and access to services. If the new system is manipulated simply to produce short-term budget savings, the inevitable result will be reduced access to services by the elderly. A successful

Medicare payment system requires prices that are adequate--only then will the program be able to meet its objective of containing costs without adversely affecting the Medicare population's receiving necessary high-quality services.

In addition, to be successful, Medicare's prospective pricing system also must establish prices that are fair. If it does not, hospitals may well be penalized for providing technologically advanced services or developing regional referral networks. The AHA has urged both the Department of Health and Human Services and the Congress to examine carefully the equity of the Medicare prospective pricing system and identify any potentially adverse consequences of moving quickly to uniform national rates of payment. Problems already have been identified for certain rural hospitals that function as referral centers and offer a comprehensive range of services. Although these hospitals offer services comparable to those found in most cities, their payment often ranges from $700 to $900 per case less than their urban counterparts.

In an effort to address equity problems, the American Hospital Association has urged Congress to study the concept of setting Medicare prices unique to each DRG based on a combination of a uniform national rate of payment and a hospital-specific rate of payment. For those DRGs that describe a uniform group of patients, the price will reflect the national average. The prices of those DRGs exhibiting substantial variation in costs, and in which severity of illness is likely to play a major role in determining the cost of treatment, would be heavily weighted toward a hospital-specific rate. We believe this

approach has great potential for improving the equity of the Medicare prospective pricing system, while preserving its incentives, until such time as the DRG system on which prospective pricing is based is adequately refined.

ASSESSMENT OF ALTERNATIVE STRATEGIES

In solving these longer-term problems, we can rely on either the incremental development of innovative delivery and insurance arrangements in both the private and public sectors or the development of intrusive regulatory mechanisms to control costs. The Quayle bills are consistent with the first approach, while the Kennedy/Gephardt legislation is an attempt to control costs through regulation. The reforms contemplated by the Quayle bills are consistent with recent developments in the health care industry, build on the principles of consumer choice and competition among alternative medical plans, and require minimum effort to implement. While these bills raise many issues, particularly the advisability of federal intervention in state regulation of insurance, elements of the bills could be used to promote the continued development of effective consumer and provider incentives.

In contrast, the Kennedy-Gephardt approach would require the creation of elaborate administrative mechanisms at both the federal and state level. At the federal level, the Department of Health and Human Services would be responsible for setting expenditure levels for each state, for evaluating the

performance of the state's rate regulation system, and for administering a federal all-payer payment system in those states that choose not to administer their own regulatory system. The states would, if they choose, administer a rate regulation program under broad federal guidelines that effectively determine both the level of rates and the rate-setting methodology. Though the bill discusses the need for "allowances" for uncompensated care, it does not recognize that the major cause of uncompensated care is the inadequacy of Medicaid programs in many states. Finally, the regulatory approach would severely constrain the availability of technological advances if it is to produce the savings projected by its authors. In fact, the only way in which dramatic reductions in expenditures could be realized is through severe restrictions on access.

CONCLUSION

The Medicare prospective pricing system is demonstrating the effectiveness of the incentives-based approach to containing health care costs. Experience to date suggests that a Medicare-only system can work to contain both Medicare expenditures and total costs. The Medicare system also is providing an opportunity to examine the complexities encountered in trying to change the incentives that influence both hospital and patient behavior while providing adequate and fair rates of payment.

In evaluating the performance of the Medicare system, the American Hospital Association urges members of Congress to keep in mind not only the issue of costs but also the kind of Medicare system necessary to meet the needs of the elderly now and in the future. If the Medicare system is implemented with a firm commitment to establishing prices that are both adequate and equitable, the AHA believes that both the public and providers will be well served. In the private sector, the AHA urges Congress to give providers, insurers, and employers time to develop innovative health care delivery methods that are responsive to the needs of consumers at a cost they are willing to pay.

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J. Alexander McMahon
President

RECEIVED OCT - 3 1984

September 20, 1984

Dear Senator Hatch

In response to your request for additional information on the questions raised by the members of the committee in response to my testimony of June 21, I am pleased to send you the following information. You personally raised three questions. My response to each of these questions follows.

1. What are the perceived successes and failures of the prospective payment system?

The most obvious success is the rapid reduction in the rate of increase in hospital costs. The most recent data indicate that hospital inpatient costs are rising at an annual rate of less than five percent. The decline in the rate of increase coincides almost exactly with the introduction of per-case payment and prospective pricing incentives by the Medicare program. Of course, innovative programs implemented by private third party payers also contributed to the decline, but these programs reinforce the basic message: incentives are an effective tool for changing hospital behavior. Thus far, relatively few problems have been identified with the prospective pricing system, although it is still to early to expect many problems to have been identified. The most pressing immediate problem is the substantial reduction in payments that have been experienced by large rural referral hospitals. The recent amendment contained in the Deficit Reduction Act substantially reduces this problem, but does not eliminate it. Similarly, the movement to uniform national prices may cause substantial problems for hospitals offering advanced, tertiary services. Finally, there are still a great many technical matters to be worked out, including the development of accurate adjustments for local variations in hospital wages, the resolution of problems with specific diagnosis related groups and the exclusion of certain exempt units.

2. What proportion of the recent decline in the use of hospitals services is attributed to the use of home health care services?

Reports from hospitals indicate that the use of home health services has increased over the past two years. Home health care has been one of the most rapidly growing components of the health care industry for the past five years, so this trend is no surprise. Hospitals are making more intensive use of home health services to ensure that the needs of Medicare patients are met after hospital discharge. The exact part of the decline in hospital length of stay due to home health services cannot, at this time, be determined. AHA will continue to monitor this trend, as part of its efforts to evaluate the impact of prospective pricing.

3. How do hospitals finance uncompensated health care?

Uncompensated healh care represents that portion of the care provided to the medically indigent that is not covered by formal public programs, e.g. Medicare and Medicaid. Some uncompensated care is financed through local governments through direct appropriations to public hospitals. The vast bulk of uncompensated care, however, is financed through charges paid by private insurers and individual patients. Historically, the federal government has not borne any part of the cost of services provided to the uninsured who are unable to pay for care using their own resources. "Bad debt" and charity care are part of the economic cost of operating the hospital. The refusal of federal and state governments to bear their share of the full economic cost of operating a hospital is the cause of "cost shifting." A substantial part of the "cost shift" is the private sectors's contribution to the cost of treating those indivduals not covered--or inadequately covered--by public programs. In an increasingly price competitive marketplace, this source of "financing" is increasingly constrained, highlighting the need for more adequate public support of the medically indigent.

In addition to your questions, Senator Edward M. Kennedy submitted four questions. My responses follow:

1. Why should we have confidence that the hospital industry can successfully attain and sustain moderate cost increases?

The major difference between the voluntary effort, whose experience is cited by Senator Kennedy, and prospective pricing is that the voluntary effort established no economic incentives for hospitals to reduce the rate of increase in their cost. In contrast, prospective pricing establishes powerful economic incentives to improve the efficiency with which hospitals' services are produced and used. The figures cited by Senator Kennedy, which go only through 1983, tell only part of the story. As indicated above, the rate of increase in hospital costs for the first five months of 1984 are less than five percent, and the trend continues to be downward. While it is too soon to tell what the rate of increase in hospital costs will be for 1984 as a whole, it is clear that the increase will be the lowest we have seen in many years. With prices from the Medicare program constrained by the rate of increase in the prices of goods and services used by hospitals, and with increasing price pressures from private payers, there is no reason to expect the rate of increase in hospital costs to accelerate in the future. Such an increase would necessarily cause a deterioration in the financial position of hospitals, a situation every hospital manager must try to avoid.

2. Do you favor major reductions in Medicare benefits to prevent the bankruptcy of the Medicare program in the early 1990s?

The American Hospital Association does not support arbitrary reductions in Medicare benefits. Such reductions can only impair access for those segments of the Medicare population most in need of public support. Similarly, the American Hospital Association does not support arbitrary reductions in hospital payment to achieve a balancing of the trust fund expenditures and revenues. Arbitrary reductions in payment will inevitably compel hospitals to cut services, impairing access to new technology and tertiary services for the Medicare population. Selective restructuring of the Medicare benefit package, with an eye to creating appropriate consumer incentives that recognize the limited resources of many Medicare beneficiaries, may be appropriate. However, such modification should be undertaken only after careful study of the consequences for access to care.

3. Why is the Medicare prospective payment system good for Medicare, but bad if applied to all purchasers of care?

The important point to keep in mind is that because Medicare is a federal program, the design of the system has to be feasible from a federal administrative standpoint. Of necessity, then, a federal payment system cannot be as sensitive as one would like to local variations in the needs of beneficiaries and in the capabilities of both beneficiaries and providers. Moreover, there are significant problems even under the Medicare program with the DRG patient classification system itself and the underlying data base. Those problems need to be solved before anyone should even consider widespread application of DRGs for other payers.

Private insurance companies and Blue Cross plans, as well as hospitals, have recently entered a period of rapid innovation in the development of financing and delivery systems. The preferred provider organization concept, competitive medical plans, and HMOs are all receiving renewed attention by both providers and insurers as well as consumers. The hallmark of these efforts is the development of a system that matches the administrative capabilities of the hospitals and insurers, the preferences of consumers and employers, and the financial goals of employers, patients and providers. A wide range of approaches has developed, each of which appears to be successful, given the goals which the involved hospitals, insurers, consumers and employers have set themselves. A uniform national approach would stifle this type of innovation, seriously jeopardizing the development of new approaches to financing and delivery of medical care. In addition, the Medicare system requires enormous amounts of data to implement. The data needed to implement the system, even though imperfect, were available only for a Medicare system. Even if the DRG classification system itself adequately accounted for severity of illness and other patient mix differences across hospitals, which it doesn't currently, the data do not exist that would be required to implement an all payer system along the lines of the Medicare program.

4. Has prospective pricing caused a decline in the quality of care?

There is no evidence to date that the quality of care has been systematically affected by the movement to prospective pricing. Individual instances of patients feeling they have been discharged "prematurely" have been reported, naturally, but these instances occurred even under retrospective cost-based payment. AHA is committed to working with its member hospitals to preserve the quality of care. The primary factor affecting hospital's ability to meet this goal is the adequacy of payment rates. Assuming payment continues to be adequate, it is safe to assume that hospital managers and their medical staffs will strive to maximize both their efficiency and the quality of their product. From the point of view of patients, it is important to remember, there is currently no financial incentive to choose one provider over another. Hence, hospitals compete for market share primarily on the basis of quality, rather than price, when it comes to the Medicare patient. Outside the Medicare program, competition occurs on both quality and price, but quality is at least as important as price.

Finally, Senator Grassley submitted two questions.

1. How do we know that the decline in utilization is not the result of a cut back in needed services?

For many years members of Congress and others have been concerned that hospitals, physicians and patients were unnecessarily using hospital services. The recent decline in hospital admissions has yet to be explained, but is undoubtedly the result of many factors including greater patient awareness of the cost of hospital care and the availability of lower cost alternatives. AHA continues to monitor utilization as part of our effort to understand the effects of prospective payment. So far, there is no indication that necessary services are not being provided. And, of course, the Congress has required the establishment of Medicare Peer Review Organizations to monitor quality.

2. Will rural areas be adversely affected by the move toward competition?

Some of the most competitive of our members are rural hospitals. Obviously, a competitive model will not work in the same way in all parts of the country. AHA continues to be concerned that the per-case approach adopted by the Medicare program may pose special problems for very small isolated rural facilities. As part of our monitoring efforts we are looking in particular at this group of hospitals. As one hospital administrator has noted, the margin for error in a small hospital is quite narrow. While in the early months under prospective pricing many small hospitals appear to have been doing better than expected, one seriously ill patient can use up a small hospital's operating margin for an entire year. To prevent these undesirable effects from occurring, AHA intends to assess the impact of prospective pricing and identify any necessary modifications in the prospective pricing system to protect this group, and other groups of hospitals, that may have special needs and problems.

I hope this information adequately responds to the questions. In addition, I have enclosed the transcript of my testimony with some editorial changes notes. I would be pleased to discuss these or other issues with you at any time.

Sincerely

J. Alexander McMahon

Enclosure

Orrin G. Hatch, Chairman
Committee on Labor and Human Resources
United States Senate
Washington, DC 20510

Senator QUAYLE. Thank you very much.
Mr. BROMBERG.

STATEMENT OF MICHAEL BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS, WASHINGTON, DC

Mr. BROMBERG. Thank you, Mr. Chairman.

We, too, would like to submit our full statement for the record and just briefly summarize it for you.

I am not going to repeat all the statistics that I hope you have heard this morning and that Alex has just given you, but we have finally put a chart into our testimony for the first time, so I should point out that after page 2, we have put our own chart in here which shows that every major indicator in the field is not only down, but down beyond anyone's expectations or hopes.

The reasons for that we think belong both in the private and public sector change of incentives. First of all, the medicare law that brought us prospective payment for the first time has clearly given us incentives 180 degrees different from any we have ever had, and we have responded. The change in behavior, not to have too many people employed per hospital simply because they are cost reimbursed, not to give extraordinary wage and benefit increases above the national average because it is cost reimbursed, to consider capital expenditures for the first time because they do increase operating costs and those are fixed for the first time, all the way down the line to trying to persuade the physicians to cooperate in lowering length of stay, doing more out-patient work, having arrangements with nursing homes and home health agencies and others for less expensive sites, and seeking discounts on supplies, all suddenly became real incentives for the first time.

The most important point I can make today is that those incentives that I just outlined, every one of them, helps non-medicare payers. In fact, those who predicted that we would simply take medicare's price, absorb it, and raise our charges to everyone else were wrong. What we have done is by lowering our labor and other costs for medicare, we have naturally lowered them at the exact same time for insurance companies in the private sector.

So, one of the reasons we are so opposed to an all-payers solution is simply because we think it is unnecessary and that the medicare incentives will not exacerbate the cost shift, but will actually reverse it.

We go through some of this on pages 6 through 9 of our testimony as to why we oppose all-payers. Let me just make two points.

One, most all-payers in this country today, most, are utility type systems. The history of utilities is certainly not one I would recommend to get costs down in health care. The game in a utility system is to pad your budget because you might get penalized the next year if you spend less than your budget. It is therefore not to go out and give discounts to PPO's or to innovate, as one of the witnesses on the last panel pointed out, but rather it is counterproductive in nature to the kinds of changes we want to see made and that are going on.

On pages 12 through 20 of our testimony, we list dozens of examples of things going on right now in the private sector, benefit re-

structuring, HMO experimentation, PPO experimentation, all of which have one thing in common. They are meant to get at utilization because that is the problem. If you can keep one patient out of the hospital, you may save thousands of dollars. If you just regulate a little bit and put a cap on, you are going to be saving pennies.

Those are some of the reasons we support the bills introduced by Senator Quayle, S. 2501 through S. 2504, to encourage the use of competitive plans in the private sector as well as to extend medicare's contracting authority to use them. Also, we support your plan to involve consumers more through information on prices and to establish a nonprofit institute for technology assessment.

Senator, your emphasis on incentives for consumer choice would accelerate the activities already underway in the private sector that we outline on these eight pages. However, in particular, our board of directors has adopted a resolution urging Congress to override provisions of some State insurance laws which prevent the development of preferred provider groups. The private-sector employers are learning to use their purchasing power for the first time to direct their employees to less costly plans and providers, and those are some of the examples we give.

The last two points I would like to make relate to an alternative called the Kennedy-Gephardt bill, S. 2424. The point I would really like to make about this is the geographic allocation problem that you get into when you try to regulate instead of letting the marketplace work. We again have a couple of charts in our testimony that show that.

However, the gist of that approach is that if we put a market basket or any cap on what an individual hospital can earn or its revenues or the total for a State, you are going to perpetuate and geometrically make worse what already is a disparity among the States in terms of resources. If you think not in terms of dollars but in lifesaving equipment, I think these charts will show what I mean.

I think the most costly State outside the District of Columbia in the country is Massachusetts. If you compare that to a State like Indiana, the chairman's State, which is right in the middle, and you put a dollar ceiling or a cap on where those hospitals are right now, regardless of whether Massachusetts may be ahead in technology, you will find that over a 5- to 10-year period, that differential becomes worse and worse in terms of resources. That is just one example of why regulation doesn't work and is the wrong way to go.

The medicare trust fund problem, in conclusion, is one that we think has to be handled in a number of ways, but among the proposals that we think need to be looked at is expanding the voucher system through a competitive health-plan option, looking for new sources of revenue like an alcohol and tobacco tax or revenues from a cap on private insurance benefits paid by employers to beef up the fund on the revenue side, benefit restructuring perhaps with some means testing and a voucher approach on the benficiaries' side. However, I would like to point out that the Medicare Trust Fund today is far better off than it was 1 year ago, and at

least 1 year or 2 further away from bankruptcy simply because of what has happened in the last year when medicare changed its incentives and went to prospective payment. That, coupled with what the private sector is doing and the reports you have heard on what has happened with the statistics, leads me to believe that the hospitals of this country know now that cost containment is here to stay and that it is real and that both the public and the private sectors are serious. The worst thing that we could do right now is enact some massive regulatory program and mix up those clear signals.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Bromberg and responses to questions submitted by Senators Hatch and Kennedy follows:]

STATEMENT BY

MICHAEL D. BROMBERG

EXECUTIVE DIRECTOR

FEDERATION OF AMERICAN HOSPITALS

BEFORE THE

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

ON THE ISSUE OF

HEALTH CARE COSTS AND VARIOUS COST CONTAINMENT STRATEGIES

June 21, 1984

The Federation of American Hospitals is the national association of investor-owned hospitals representing over 1,100 hospitals with over 135,000 beds. Our member management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

We appreciate this opportunity to present our views on health care costs.

Hospital Cost Increases Have Slowed Dramatically

Hospital costs are often compared to changes in the consumer price index (CPI) or changes in the American Hospital Association marketbasket, which measures changes in the prices of what hospitals buy -- nursing services, equipment, supplies, capital, etc. This is an extremely misleading comparison. The CPI and hospital marketbasket measure price changes only. Hospital cost increases are the product of both higher prices and increases in the volume as well as sophistication of services. Since costs are a function of both volume and price, one would normally expect

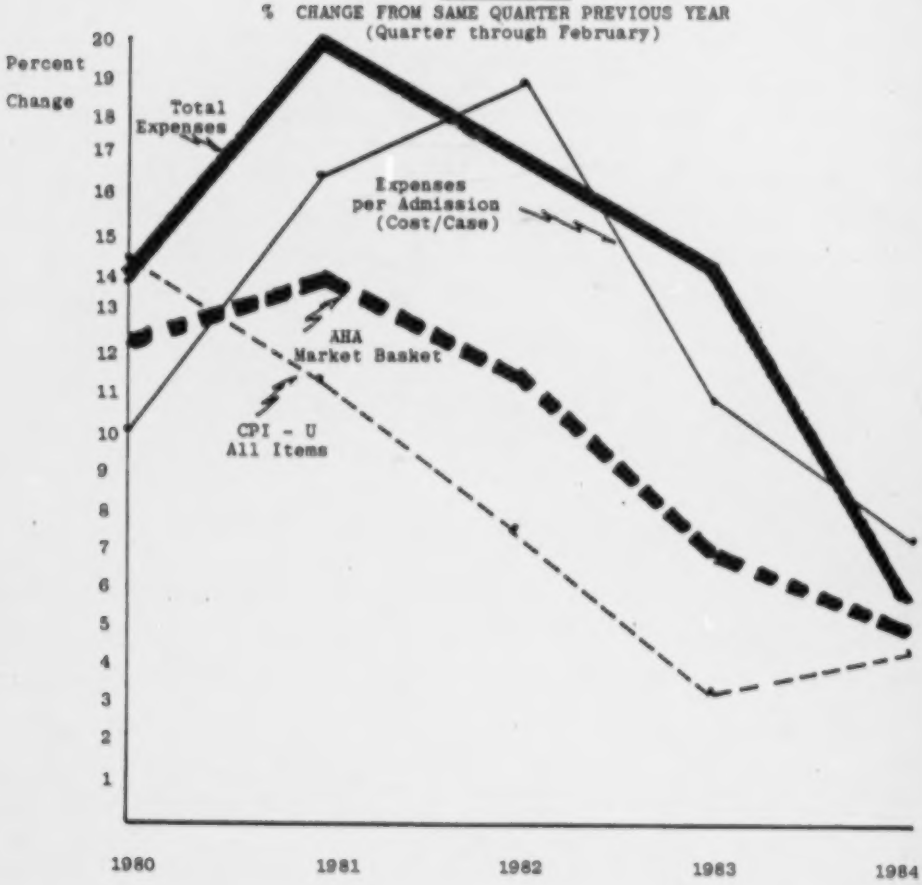
costs to rise faster than prices alone. This is just what has been happening since the mid-60s until quite recently.

We have good news about hospital costs. The growth in total costs and costs per case is declining dramatically relative to the consumer price index and the hospital market-basket. What makes this performance especially remarkable is that prices themselves have been rising much less rapidly. From the quarter ending February 1982 through the quarter ending February 1984, the rate of increase in total hospital expenses dropped 65 percent, from 17.2 percent to only 5.9 percent (Exhibit One). The rate of increase in expenses per admission dropped by over half from 19 percent to 8.2 percent (Exhibit One). The decline in the growth rate of total hospital expenses and expenses per admission has been much greater than the decline in the consumer price index which over the same period dropped by 40 percent from 7.7 percent to 4.6 percent.

A year-to-year comparison of the quarter ending in February 1984 shows that 1984 admissions, lengths of stay, and staffed beds all actually declined compared to the same period a year earlier. Admissions went from a 2.7 growth to a 2.1 decline. Lengths of stay declined from 7.2 days to 6.9 days, and staffed beds went from a 1 percent growth to a .4 percent decline.

EXHIBIT ONE

% CHANGE FROM SAME QUARTER PREVIOUS YEAR
(Quarter through February)



Year-to-year comparisons for the month of February show a pattern similar to the quarterly comparisons. In February 1984:

--65 and over inpatient days were down 4.9 percent from February 1983;

--Under 65 inpatient days were down 4.3 percent;

--Full-time personel declined .6 percent; and

--beds declined .5 percent.

The utilization numbers for March remain negative. Hospital cost containment is already here.

These favorable cost trends are not temporary but are the first fruits of a national commitment to reduce the rate of hospital utilization. Both government and business have finally gotten serious about cost containment. The cost control incentives created by Medicare's historic shift from cost reimbursement to fixed payment are well known. Not so widely known but perhaps more important are the new activities in the business community. Until the turn of the decade, the emphasis in the private sector was on enriching

the tax-free benefits for their employees and on assuring trouble-free payment of claims. The natural consequence of a spare-no-expense mentality with health care benefits being subsidized by government was that health care spending exploded. By 1982, business outlays for the health care of their employees were about 30 percent of profits.

Buffeted by lower cost foreign competition, corporations starting in the early 1980s decided to become much more prudent purchasers of health care and have correctly perceived that the key to controlling health care costs is to minimize unnecessary utilization.

Preliminary results have been very encouraging. According to a report issued by the Business Roundtable's Task Force on Health for 69 companies who responded to a survey the cost of the average health program per recipient had risen 8.4 percent from the first quarter of 1983 to the first quarter of 1984, compared to 12.7 percent for the same period a year earlier.

New Medicare Incentives

The new Medicare prospective payment system is already causing a change in provider behavior greater than any change we have seen since Medicare began.

The provider community is responding to Medicare's DRG rates. How society will respond is less clear but will depend on whether the rates are fair and revised in time to assure the continued quality of services and access to care that Americans have come to expect.

Hospitals understand the new message as one which encourages them to take the following actions:

- Limit the growth in hospital employees.
- Limit wage and benefit increases.
- Reconsider capital expenditures which increase operating expenses.
- Consider specialization in those DRGs which are economical.
- Urge physicians to order more pre-admission testing to reduce length of stay and inpatient tests.
- Urge physicians to order fewer ancillary tests per patient.

- Make arrangements with alternative, less expensive providers for post-hospital care.

- Seek price discounts on supplies.

Every one of the eight actions listed here produces a common benefit to hospitals. They produce cost-containing dollars which increase the bottom line profit or surplus. Any of these actions taken under the old law would have only decreased revenues and added nothing to profit or surplus.

As hospitals achieve these eight cost-containing approaches, the impact on non-Medicare patients has already been substantial. Those who predicted more cost shifting assumed that hospitals would simply suffer large losses on nearly half their business while raising prices to the other half. That scenario was wrong because it underestimated the impact of Medicare policy on total costs and also underestimated the reluctance and resistance of other payors to further price increases.

Some recommend an all-payors system presumably run by a government agency. If the problem were monopoly pricing, this would be in order. But it is not. The real problem is too much demand, which an all-payors system does not affect. Growth in the rate of hospital admissions and the volume and

sophistication of services accounted for over 50 percent of the increase in hospital spending above general inflation. That demand was fueled by a tax system which subsidizes health insurance without limit and by the absence of co-payments which restrain utilization. All-payors systems do not address these basic causes of soaring demand.

Besides failing to deal with the central problem of too much utilization, an all-payors system would make things worse. Here is a short list of adverse side effects:

- All payors, also known as state rate setting or price controls, would stifle delivery system innovation -- the best hope for greater cost effectiveness.

- There is no incentive for price competition under price controls.

- Bureaucratic preferences or political clout, rather than management performance, would determine who gets capital. Decisionmaking would become politicized and centralized.

- The consumer has no say in how or where resources are allocated.

- Future patients get shortchanged because the political pressure for "savings" forces hospitals to strip maintenance and depreciation reserves to cover operating expenses. This causes them to run in the red and eventually turn to taxpayers for a bailout.

- The evidence is strong that rate setting does not improve hospital efficiency. There is general agreement that cost-based reimbursement is not conducive to efficiency. A recent study examining the effect of rate-setting programs on efficiency showed that there were "no systems where reimbursement received by an institution was not largely determined by a hospital's own costs....Rate setting in general has not been successful in influencing the distribution of hospital expenditures per admission and per day. States with the policy of trying to eliminate technical inefficiency have not been any more successful than those without this policy."

- Finally, the 'all-payor element' should prove to be unnecessary in a system that is driven by the new Medicare incentives. Private insurers, business, and other payors are already beginning to negotiate their own prospective payment plans with hospitals,

relieving the pressure for state or local governments to install price controls. The only pressure for such utility-type regulations is likely to come from those hospitals which are unable to contain costs and view state systems as a way out of the Medicare rate structure.

A Market Strategy

The large body of studies examining the cause of health care expenditure growth all point to the same conclusion: The problem is not inefficiency, but utilization -- patients, freed from the burden of payment, demand more; and physicians and hospitals, unrestrained by cost-based reimbursement, provide more.

Our present system of health care financing has desensitized providers and consumers to the true cost of health care through the extensive use of first-dollar coverage and low copayment rates. The situation has been aggravated by cost reimbursement, which encourages excessive spending. The result is intense quality competition but little price competition.

Creating cost consciousness in providers and consumers is intrinsic to any solution to rising health costs. Without price awareness, demand for health services is infinite.

A large body of economic analysis strongly supports the conclusion that financial incentives have a significant impact on utilization. Utilization goes down as cost sharing goes up. Here is a typical finding:

- "...when compared with full coverage, a 25-percent copayment reduces utilization and expenditures by 20 percent."

  (Charles E. Phelps, "Health Care Costs: The Consequences of Increased Cost Sharing," Rand Corporation, Santa Monica, California, November 1982.)

The President's Commission for the Study of Ethical Problems in Medicine has published a volume on "Securing Access to Health Care," which provides some sound advice on how government should establish its priorities in health expenditures.

With reference to the tax-free treatment of employer-purchased health insurance to employees, the Commission noted:

"The employer-exclusion provision gives a larger subsidy to those with a smaller need for financial protection and exacerbates the tendency of lower-income people to be less well insured than those with higher incomes." The Commission goes on to say, "This pattern of care is difficult to justify from an ethical standpoint. There seems to be little reason for such government assistance to middle- and upper-income individuals, most of whom could take financial responsibility for their own care...without undue hardship."

We heartily endorse this position and believe that on fairness grounds alone the tax cap should be applied forthwith.

The tax subsidy, now estimated at about $29 billion, represents substantially more than the federal government spends on Medicaid.

Eliminating the open-ended employer contribution while encouraging equal contributions to all employee health insurance plans will stimulate competition among health plans and providers. Also, consumers of health care must have some financial stake in the system through some cost sharing of premiums and copayment of incurred costs in order to bring

some market-oriented restraint into decisions about utilization and choice of plans. Higher premium and delivery costs should be borne by the party selecting the plan or provider.

Private Sector Initiatives

Just as we have brought price competition to hospitals through enactment of Medicare prospective payment for hospitals, we need to bring price competition to the insurance industry. We must, however, give employers and employees the incentive to be cost conscious in their purchase of health insurance plans.

For these reasons we support the general approach outlined by Senator Quayle in four bills (S. 2501 - S. 2504) introduced on March 29, 1984 to encourage the use of competitive medical plans and preferred provider organizations in the private sector as well as through Medicare contracting authority and to study increased consumer involvement through greater availability of price and other information and to establish a private, non-profit Institute for Health Care Technology Assessment.

Senator Quayle's emphasis on incentives for consumer choice of competitive health plans would accelerate activities already underway in the private sector and assure that

Medicare offers similar choice of plans to program beneficiaries.

In particular, the FAH Board of Directors has adopted a resolution urging Congress to override provisions of some state insurance laws which prevent the development of preferred provider organizations.

In the private sector, employers are learning to use their purchasing power to direct their employees to less costly health plans and providers.

Examples of successful private cost containment initiatives include the following:

General Mills

Almost 80 percent of the General Mills employees in the Minneapolis area belong to an HMO. Increases in HMO rates have been one half to three quarters as great as the rates for the General Mills indemnity plan.

Deere & Company

Deere and Company promoted the development of an HMO for employees and their dependents. Hospitalization rates have declined from

1400 days per 1000 persons to less than 500 days since the Quad City Health Plan became operational. Premium increases have been running at the rate of only nine to ten percent annually for the last three years.

Zenith

Zenith has created a medical services advisory program. A utilization review specialist advises Zenith employees and their physicians as to:

- average cost per day for most Chicago hospitals;
- average length of stay per medical procedure;
- expected hospital charges for a procedure; and
- how much the employee can expect to pay.

These measures help employees and physicians compare their expected charges to the average. Since the employee is paying part of the bill, he has an incentive to ask the doctor to use a lower cost hospital provided quality is not compromised. If an employee is reluctant to talk with his doctor about cost issues, the Zenith utilization specialist will do it for him. Zenith limits its role to providing information; it does not mandate that physicians change hospitals.

Even though the medical services advisory program covers only salaried employees, Zenith saved about $4500 a week during the first two months of the program. Potential savings are many times greater.

Ameritrust Bank

Ameritrust Bank of Cleveland found that despite a 15-percent reduction in its work force, annual employee health benefit payments had risen 731 percent since 1975. Starting in the summer of 1983, the bank gave employees a choice between the usual health insurance plan and three preferred provider organizations (PPOs). If an employee uses one of the PPOs, he and his family pay no doctor bills. If they use a non-PPO physician, they pay the first $150 to $300 and then 20 percent of medical bills up to $2300. Bills beyond that amount are paid for by the plan.

Monthly premiums are as much as $25 lower a month than the comparable local Blue Cross plan. The bank has also implemented a utilization review program where a nurse or medical professional reviews patient charts. About 20 percent of the bank's employees have signed up.

Quaker Oats

Each eligible employee receives a $300 credit that can be used in one of three ways:

- to cover the first $300 of hospital expenses for illness or injury;

- to receive tax-free reimbursement for various health care services not covered; or

- to receive cash for any balance.

If an employee and his family have combined illness or injury expenses greater than $300, Quaker pays 85 percent of the costs up to $5000 (inflation adjusted), 100 percent thereafter. If the amount Quaker actually spends on an employee is less than the budgeted amount per employee, a dividend is added to the following year's expense allowance.

Although official year-end results are not yet available, it appears to Quaker executives that the plan is a success. The rate of increase in health care spending through November 1983 has been significantly lower than for the prior year.

Mobile Oil

Mobil makes the pre-set contribution towards a family's annual health plan. The monthly dollar amount offered by Mobil is compared to the monthly premium paid for a family's coverage. If the premium is lower, the family keeps the difference; if higher, the family pays the difference.

LTV

LTV has established medical "expense accounts" with an overall benefits bank which is funded by employee contributions under Section 125 of the Internal Revenue Code. Employees are permitted to reduce their salaries in exchange for certain approved tax-free benefits. Any unused funds in an employee's benefit bank are returned to him each year and are considered part of taxable income.

Dupont

Dupont, in response to rising costs and employee disgruntlement, has implemented its MedCap plan which has two options. The first is frill hospitalization coverage with 20 percent copayment for physician and outpatient services. The second option gives greater catastrophic coverage but requires greater front-end patient cost sharing.

Stouffer Corporation

Stouffer Corporation calculates that its two dental PPOs, in operation for over two years, have reduced dental expenses 35 percent. Its two medical PPOs -- one hospital-based and the other physician-based -- have reduced costs 23 percent. Both of these PPOs are non-discount, relying instead on provider incentives to control costs by pre-admission screening, utilization review, and retrospective data analysis.

Donald Flagg, Stouffer's Vice President for Human Resources, recently told the House Energy and Commerce Subcommittee on Health that "competition between PPOs is one of the biggest factors coming out of the PPO movement and at this time offers us the greatest opportunity to affect positively both the cost and the quality of health care."

FMC

FMC reports that since 1981 it has saved 11 percent of its health costs through 12 design changes such as:

--Mandatory second opinions for 15 elective procedures. This program alone accounted for almost half the savings.

--Audit of long-term disability claims. Five percent were found to be ineligible.

--Review of all hospital bills over $10,000. In every case, a net savings was realized.

--The availability of health maintenance organizations (HMOs). FMC has contracts with 35 HMOs.

Alcoa

Alcoa in 1983 expects to reduce its disability costs 20 percent just by a change in policy. Formerly, the company did not have an employee return until he could do the same job and as much work as before he left. Now, Alcoa wants an employee back as soon as it is safe from a health standpoint. When this program was implemented, the number of people drawing disability benefits dropped 57 percent at one plant.

Another major health care cost containment program at Alcoa is a two-part insurance plan. The first is a health insurance plan with a $100 deductible and a 20-percent employee copayment up to $700, after which all costs are covered. The second is a $700 employee benefit security fund. Employees can use this fund to pay for deductibles and copayments. They must withdraw no less than $200 at a time. An employee will receive a check for any balance left over at the end of the year. Withdrawals for qualifying medical expenses are tax-free; checks for unused balances are taxable.

Illinois Central Railroad

Illinois Central Railroad has instituted a program called CARE (Cost Awareness Recovery Effort) in which employees audit their hospital bill, and if they report overcharges, they can earn 25 percent of the overcharge.

Owens-Illinois Corporation

Owens-Illinois provides nurse-coordinators for hospitalized workers as a means of reducing the number of hospital days. It also encourages second opinions for certain types of surgery.

United Technologies Corporation

United Technologies links its contributions to Manchester Memorial Hospital in Manchester, Connecticut to certain cost-efficient goals which the facility must meet such as an increase in outpatient surgery and a reduction in the average hospital length of stay.

Borden

Borden has focused on increasing employee cost sharing; in return it offers higher benefits in other areas such as dental, long-term disability, and employee savings. The major medical deductible has been raised to $150 with an out-of-pocket stop loss of $5000. Employees are also asked to pay part of the cost of the first few days of hospitalization with a stop loss of $1000.

State Controls Undermine Price Competition

We oppose S. 2424, the Kennedy-Gephardt bill, "The Medicare Solvency and Health Care Financing Reform Act of 1984," for several reasons:

--The flow of dollars to hospitals would be unfair, arbitrary, and unrelated to the relative ability of individual hospitals to deliver quality care at competitive cost.

--The hospital system would become very different from what the public would have if it were free to make its own choices in a price- and quality-competitive market.

--The legislation would have no effect on those factors accounting for over 75 percent of the growth in hospital spending:

	% contribution to spending growth
• general inflation	59.4
• population	8.3
• hospital-specific inflation	9.4
• subtotal	77.1

S. 2424 would have minimal impact on hospital-specific inflation for two reasons. First, in the initial period of the bill, hospital labor costs -- accounting for over half of total costs -- would be passed through automatically. Second, the proposed controls on a hospital's rates would not lower the costs of its non-labor inputs; controlling the price of an apple pie does nothing to lower the cost of apples.

--The significant savings promised by S. 2424 are possible only if medically beneficial treatments are withheld from people who are very sick. Greater use of new technology, accounting for 25 percent of hospital spending growth, has necessarily been concentrated on that 10 percent of the patients who consume about two-thirds of the dollars.

--Patients in low hospital-cost states would be at a permanent disadvantage to patients in high-cost states. For example, by 1990 Massachusetts hospitals would receive $2200 more per case than the average hospital nationwide. The following chart reflects the geographic inequities of this approach:

	1982	Above Average	1990	Above Average
Massachusetts	$4104	$1221	$7463	$2220
Missouri	2915	32	5301	58
US Average	2883	--	5243	6
Wyoming	2009	(874)	3653	(1590)

Figures for all states represented by Senators on the Labor and Human Resources Committee are attached as Exhibit Two. These figures are based on HCFA projected increases in the hospital marketbasket plus one percentage point.

S. 2424 is designed to force hospitals to join organized health care delivery systems before it is clear that this is what the public wants. Such a radical change may or may not be a good idea, but it should be up to the public to decide through their choices in the marketplace.

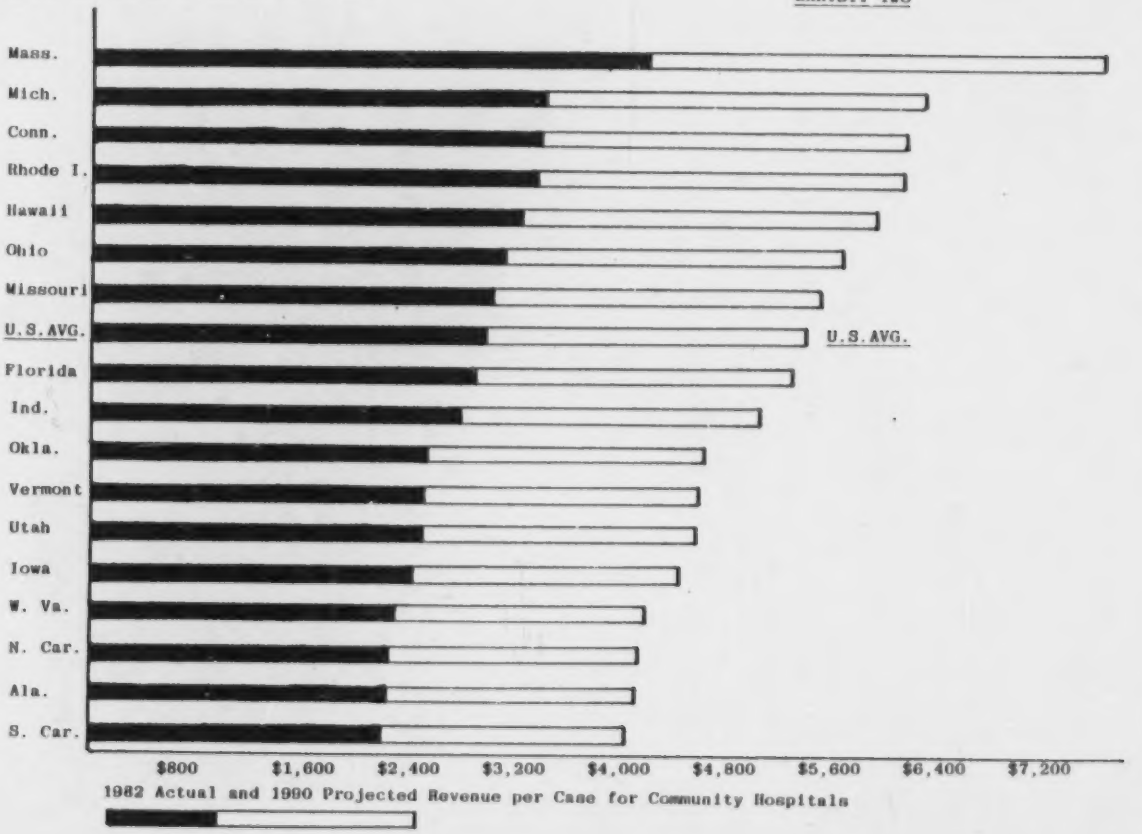
Besides being inappropriate, the Kennedy-Gephardt legislation is unnecessary. Literally hundreds of private sector initiatives have sprung up and although a new phenomenon, many are enjoying considerable success.

The Medicare Trust Fund

Medicare can be made solvent at minimum loss of medical benefit without punitive legislation. We believe the right

STATES REPRESENTED ON SENATE
LABOR AND HUMAN RESOURCES COMMITTEE

EXHIBIT TWO



approach is legislation that makes physician and hospital success dependent on both good cost control and acute responsiveness not to a bureaucracy but to patients.

The Medicare Trust Fund crisis will force a public debate on society's obligation to finance needed health care services. One aspect of the debate will be a test of the public's willingness to find new sources of revenues, such as an increased alcohol and tobacco tax which we recommend, to meet the government's commitment to assure the elderly access to medical care. Those new revenues are essential if we are to avoid a reduction in the level of quality care our nation expects. With adequate funding from new revenues and with adequate DRG rates, hospitals can contain costs for all payors and still provide a quality product.

The government's commitment to the elderly needs to be restated in terms which assure the elderly that their health benefits will be paid from a financially stable trust fund. It should also be made very clear to beneficiaries and providers that the government's commitment to pay for covered services does not mean there is no budgetary limit on the quantity of services that may be consumed. Until we address this issue, there will be no real solution to the increasing pressures on the Medicare Trust Fund. Benefit restructuring to revise beneficiary copayments and require a voucher option are two essential elements of any set of reforms designed to restrain utilization of services.

ATTACHMENT ONE

1982 ACTUAL AND 1990 PROJECTED REVENUE PER CASE
FOR COMMUNITY HOSPITALS
IN STATES REPRESENTED ON
SENATE LABOR AND HUMAN RESOURCES COMMITTEE

STATES	1982	1990
Massachusetts	$4,220	$7,674
Michigan	3,474.5	6,318
Connecticut	3,409	6,199
Rhode Island	3,404.8	6,192
Hawaii	3,291.5	5,984
Ohio	3,152.3	5,731
Missouri	3,059.4	5,565
U.S. Average	3.008.8	5,470
Florida	2,959.5	5,382
Indiana	2,821.8	5,130
Oklahoma	2,589.1	4,708
Vermont	2,577.6	4,687
Utah	2,574.7	4,682
Iowa	2,493.3	4,534
West Virginia	2,356	4,284
North Carolina	2,326.6	4,238
Alabama	2,325	4,228
South Carolina	2,269.5	4,126

Assumption: Hospital revenues per admission increase annually at HCFA's projected increase in the hospital marketbasket plus one percentage point.

QUESTIONS SUBMITTED BY SENATOR ORRIN G. HATCH FOR MR. MICHAEL BROMBERG

1. How has market competition been affected by the capping of prospective Medicare payment systems? Can you comment on your perceived successes and failures of the Prospective Payment system?

2. What impact does competition from specialized for-profit service centers (outpatient clinics, emergency centers, surgicenters) have on full service hospitals?

QUESTIONS FROM SENATOR EDWARD M. KENNEDY TO MICHAEL BROMBERG, FEDERATION OF AMERICAN HOSPITALS, TO BE SUBMITTED TO THE RECORD

1. In 1979, you testified before the Ways and Means Committee that, "The success of the voluntary effort cannot be disputed," when the issue was hospital cost containment. Shortly after your efforts, and those of others, successfully killed that bill, the successful voluntary effort seemed to fade away. Inpatient hospital costs increased 16.8% in 1980, 18.4% in 1981 and 15.6% in 1982. Given that history, why should we have confidence in the same kinds of proposals for voluntary efforts that you are making today when hospital costs were 2½ times the C.P.I. last year? A few quarters of declining inflation rates after an orgy of excessive inflation hardly seems a good basis for public policy.

2. Kennedy-Gephardt essentially extends the prospective payment system already legislated for Medicare to all purchasers of hospital services, except where a State chooses to use a different approach to controlling hospital costs. Explain why a system you ~~strongly~~ support as ~~terrible~~ good for Medicare is terrible if it's extended to everybody else.

3. I am astounded at your recommendation that increased cost-sharing for Medicare beneficiaries would be fair and appropriate and lead to a dramatic reduction in unnecessary use of services. Are you aware that the current Medicare deductible is equal to about one month's worth of income to a widow receiving an average size Social Security check? How much cost-sharing do you think we need?

4. How do you square the assertion in your testimony that additional consumer cost-sharing is essential to deal with the cost problem by reducing excessive demand with the HMO experience. HMO's typically apply no cost-sharing for service, but they have an exemplary record of controlling utilization without a decline in quality?

5. Without enactment of Kennedy-Gephardt, Medicare will be bankrupt by 1991 and have a trillion dollar deficit by 2005 unless we cut benefits by one-third or increase payroll taxes 50 percent. Do you support those alternatives or do you have any credible projections indicating your recommendations can make Medicare solvent without major benefit cuts or tax increases?

Federation of American Hospitals'
Responses To Questions From
Senator Orrin G. Hatch
On Health Care Costs and Various Cost Containment Strategies

(1) The Medicare prospective payment system has reversed management incentives across the board and has consequently helped to increase price competition in the private sector by encouraging cost reductions. Specific examples include an end to the increase in total employees which has cut costs for all payers as well as reductions in lengths of stay and increased awareness on the part of physicians that costs must be contained.

(2) Competition from specialized centers has contributed to the reduction of hospital admissions and has also caused a reduction in hospital charges in certain markets. A third result has been the expansion of hospitals into outpatient services, including surgi-centers, home health services, and other lower cost alternatives to inpatient care.

Federation of American Hospitals'
Responses To Questions From
Senator Edward M. Kennedy
On Health Care Costs and Various Cost Containment Strategies

(1) The Voluntary Effort of 1977-1979 was a success but was never meant as a long term solution to the health cost problem. Our organization supported basic structural reforms to achieve long term cost containment before, during, and after the Voluntary Effort.

We called for a Medicare prospective payment system 15 years ago. We supported a ceiling on tax-free employer purchased health insurance five years ago. We support increased cost sharing based on ability to pay and a Medicare voucher option. The dramatic decline in the rate of increase in health costs is based on real changes, in part due to the reduction of general inflation and in part due to the passage of Medicare prospective payment and increased private sector experimentation with health benefit restructuring, including increased cost sharing and alternative health plans.

(2) A single prospective payment system for a government program -- a single payer -- makes sense, however, private payers should negotiate their own contracts and payment systems rather than rely on government price controls. The government does not have the expertise to set appropriate rates or determine quality of care or technology levels for private sector payers or patients. We also believe government price controls would stifle innovation with alternative health systems.

(3) Our proposal for increased cost sharing is based on ability to pay. We are not proposing increases for the elderly/poor but rather a sliding scale cost sharing schedule based on income.

(4) HMOs have the economic incentive to reduce health costs, particularly hospital stays and we support a voucher option which could increase their market share. At the present time most providers are not HMOs and until consumers express other preferences, cost sharing is an important way to restrain utilization in the fee for service area.

(5) The Medicare system must be made financially sound without drastic benefit cuts or payroll tax increases. We believe many of the Advisory Counsel on Social Security recommendations of 1983 should be adopted. Among those we favor are increased alcohol and tobacco taxes; a ceiling on tax-exempt employer contributions to private health insurance with earmarking of revenues to Medicare; and a broader Medicare voucher option.

Senator QUAYLE. Thank you. As usual, you are not short on ideas on how we should proceed.

Dr. Schenken.

STATEMENT OF JERALD R. SCHENKEN, M.D., VICE CHAIRPERSON, AMERICAN MEDICAL ASSOCIATION COUNCIL ON LEGISLATION, OMAHA, NE

Dr. SCHENKEN. Thank you, Mr. Chairman.

My name is Jerald Schenken. I am in practice in pathology in Omaha, NE. I will shorten my remarks and submit my full statement for the record, if that is satisfactory.

Senator QUAYLE. Please do.

Dr. SCHENKEN. As you may know, last February, the American Medical Association sent a letter to every physician in the country urging each to voluntarily freeze his or her fees for a 1-year period and to continue to take into account the financial circumstances of each patient, especially the unemployed, the uninsured, and those under medicare, and to accept reduced fees when warranted. The voluntary freeze proposed by the AMA applies to all physicians and includes charges to all physicians' patients, including those that are covered by medicare. This action taken by the AMA also is in line with a 1-year freeze of medicare payments to physicians as proposed by the President in his budget.

I am pleased to say that recent data available to us indicates that over 75 percent of the Nation's physicians are complying with the voluntary freeze. We anticipate that the resulting savings to the American people could approximate $1.4 billion.

Mr. Chairman, from what I have heard today, the objectives of the AMA are the same as the objectives of the members of your committee. It is only that our methods differ, and I think our methods may differ probably less than a superficial evaluation would reveal.

In dealing with health-costs issues, we urge you to view the whole issue in perspective. All health-care cost increases cannot and should not be considered in a negative light. Partly as a result of these increased expenditures, many people now have better access to a quality health-care that was almost unknown 10 or 20 years ago, reflecting more advanced and technologically improved health-care services. Although we have a way to go in various areas of our public and private sector, by every measure we have, the overall health of the American people has never been better.

Furthermore, the population of this country is again, and placing greater demands on the health-care delivery system. The nearly universal coverage of medical expenses by health insurance or Government health programs has insulated most Americans from consideration of cost of medical services they receive. By the way, in terms of competition, we might just parenthetically put in here there has been competition in the health and medical field for years, rural and urban, family practitioners, obstetricians, and so on. What we haven't had is cost purely on the basis of price, and I don't think that you are suggesting or we are suggesting that purely price cost without consideration of quality or access would be desirable. I certainly would hope so.

Many economists feel that this first dollar and insulation is partly responsible for the continuing rise in medical care costs, and many of the witnesses have said so. One Government response to this situation has been to impose limits on the supply of capital intensive health systems through the health planning program. It has been AMA policy that the demand for services should also be addressed. Thus, competition and individual choice should be enhanced as alternatives to regulation.

To help assess and guide the Federal legislative proposals impacting on the Nation's health insurance system, the AMA has developed its consumer-choice principles. They spell out a policy for greater individual choice and for incentives for prudent behavior of individuals. It is intended that all principles be considered together when reviewing any proposed legislation, and they are included in my formal statement.

Mr. Chairman, regarding S. 2424, the AMA has carefully studied this complex bill and we urge its rejection. The Kennedy-Gephardt bill calls for a radical restructuring of the payment mechanisms for health-care delivery throughout the country without the benefit of even a single demonstration as to how such a system would work and what effect it might have on the health-care delivery and the health-care status of our population.

The bill would inevitably result in retention of health-care services for individuals in need of hospital care because of its arbitrary establishment of hospital revenue caps. By capping hospital revenues and imposing heavy penalties based on preset revenues and preset admission limits, the bill would establish incentives for hospitals and physicians to reduce services, a goal that is usually tied with a reduction in overall quality of health services.

We urge you to consider changes in which the incentives are appropriately guided and not guided in a way which might interfere with the proper relationships between patients and physicians. The AMA objects to the Kennedy-Gephardt bill for a number of specific reasons which are included in our statement.

Mr. Chairman, decisions concerning how many health-care dollars there will be for tomorrow and how they are to be directed are as much a life-and-death decision for an individual as a physician can face in the course of his practice. We urge you to keep this fact foremost when you and other Members of the Congress consider the future of our Nation's health-care delivery system.

Let me say one final word about incentives. On the part of the AMA, we are for them, we recommend them, and we teach them, but we want them to be proper, we want them to lead to retained quality and access, and we do not want them to lead to restricted services and certainly do not want them to have an incentive so that we will not be able to take care of those patients that are extremely ill and who need our services.

Thank you very much, Mr. Chairman.

[Prepared statement of Dr. Schenken follows:]

SUMMARY
STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Labor and Human Resources

United States Senate

RE: Health Care Costs Strategy

Presented by:

Jerald R. Schenken, M.D.

June 21, 1984

AMA's Call for Voluntary Physician Fee Freeze Last February, the American Medical Association sent a letter to every physician in the country urging each to voluntarily freeze his or her fees for a one-year period and to accept reduced fees when warranted. Recent data indicates that 73% of all of the nation's physicians are complying with this voluntary freeze, and the resulting savings to the American people from this action will be approximately $1.41 billion.

Health Care Cost and Delivery in Perspective All health care cost increases cannot and should not be considered in a negative light. Large numbers of individuals now have better access to a quality of health care, reflecting more advanced and technologically-improved health care services. The population of this country is aging and placing greater demands on the health care delivery system. Inflation also has been a substantial factor that has contributed to the increase in health care costs.

AMA Consumer Choice Principles The nearly universal coverage of medical expenses by health insurance or Government health programs has insulated most Americans from consideration of the cost of medical services. Many economists have said that this is partly responsible for the continuing rise in medical care costs. The AMA has developed principles which spell out a policy for greater individual choice and for incentives for prudent behavior by individuals.

Pending Legislation There are many pending bills that deal with the area of health care costs. This statement will address four bills: S. 2501, S. 2502 and S. 2503, introduced by Senator Quayle, and S. 2424 introduced by Senator Kennedy.

S. 2501 - Public Health Service Act Amendments of 1984 This bill would provide certain preferances for Preferred Provider Organizations (PPOs) similar to those now available for HMOs and Competitive Medical Plans. The bill would also preempt certain state laws concerning the regulation of PPOs. The AMA does not believe that S. 2501 should be adopted. Undue incentives for a particular form of health care such as HMOs or CMPs should not be provided. The Association also believes that issues involved in formulating insurance laws are best dealt with at the state level and that states should retain ability to develop their own laws governing PPOs.

S. 2502 Medicare Preferred Provider Arrangement Act This bill would provide for coverage for PPAs under the Medicare law. The AMA favors a pluralistic approach to health care delivery. This bill, however, poses risks of unfair competition and limitations of choice and benefits. The PPA concept should be subject to a demonstration project prior to considering its incorporation into the Medicare program.

S.2503 - Health Care Consumer Information Act This bill calls for a study of cost information programs in four states and would establish a federal program to develope information methology and disemination. The AMA believes that this legislation is unnecessary. The Department of Health and Human Services already has authority to conduct studies of state programs as called for in the bill, and the Association questions the feasibility of developing methodologies for determining the quality of health care and providing consumers with adequate information.

S. 2424 - The "Medicare Solvency and Health Care Financing Reform of 1984" The Kennedy-Gephardt bill calls for a radical restructuring of the payment mechanisms for health care delivery throughout the country without the benefit of even a single demonstration as to how such a system could work, and what effects it would have on health care delivery and the health status of the population. The AMA does not believe that it should be adopted.

Conclusion The AMA urges Congress to act to help assure continued access to the high level of quality care currently provided by our health care system. Great advances in the American people's health status has occurred because this country has devoted necessary resources to the health care sector. This policy should continue. Further strides can be made by encouraging the American public to prevent illness through adoption of healthier lifestyles. The AMA will continue to take a leadership role in seeking cost effective medical care. However, no actions should be taken that would reduce access to and quality of necessary medical care.

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STATEMENT

of the

American Medical Association

to the

Committee on Labor and Human Resources
United States Senate

RE: Health Care Costs and Selected Pending Legislation

Presented by:
Jerald R. Schenken, M.D.

June 21, 1984

Mr. Chairman and Members of the Committee:

My name is Jerald R. Schenken, M.D. I am a physician in the practice of pathology in Omaha, Nebraska and I am Vice Chairman of the Council on Legislation of the American Medical Association. Accompanying me today is Ross Rubin, Director of the AMA's Department of Federal Legislation. The American Medical Association is pleased to have this opportunity to present this testimony on health care cost. The Association has recognized that the increases in the cost of health care is an issue that society must address. We are proud to say that physicians have not shirked this responsibility.

AMA's Call for Voluntary Physician Fee Freeze

Last February the American Medical Association sent a letter to every physician in the country urging each to voluntarily freeze his or her

fees for a one-year period and to continue to take into account the financial circumstances of each patient--especially the unemployed, the uninsured, and those under Medicare--and to accept reduced fees when warranted. The voluntary freeze proposed by the AMA applies to all physicians and includes charges to all physicians' patients including those that are covered by Medicare. This action taken by the AMA also is in line with a one-year freeze of Medicare payments to physicians as proposed by the President in his budget.

The American Medical Association believes that a voluntary fee freeze will be especially helpful in easing the current deficit problems facing the federal government. Recent data indicate that 73% of all of the nation's physicians are complying with this voluntary freeze, and the resulting savings to the American people from this action will be approximately $1.41 billion.

Health Care Cost and Delivery in Perspective

The American Medical Association recognizes that health care costs in this country have been steadily increasing. In 1965 total health care expenditures were approximately $39 billion and represented 5.9% of the gross national product (GNP). In 1982 these figures had increased to approximately $321 billion, and the percentage of GNP for health expenditures was at approximately 10.5%. The Administration's projections indicate that total health care expenditures will exceed $750 billion by 1990, and that this will account for approximately 12% of the GNP.

Mr. Chairman, during the course of these hearings and future considerations on the health care sector of our economy, we urge you to view this issue in perspective and recognize the fact that all health care cost increases cannot and should not be considered in a negative light. Significant elements of these increases in costs reflect the fact that many people now have better access to a quality of health care that was almost unknown as little as ten years ago, reflecting more advanced and technologically-improved health care services. Furthermore the population of this country is aging and placing greater demands on the health care delivery system. The following facts directly relate to the increase in health care costs:

- From 1971 to 1981, the most substantial element in the growth in expenditures for health care was general inflation. According to an article published in the March 1983 issue of Health Care Financing Review, general inflation "accounted for approximately 57% of the increase in total systems costs (personal health care costs) for the period 1971 to 1981."

- Approximately 8% of the growth in health care expenditures from 1971 to 1981 is directly attributable to the aggregate population growth over that period of time.

- Between 1983 and 2025, the total population is projected to grow by almost 30 percent, with the elderly population doubling to a total of 58 million or 19.4 percent of the total population. The over age 85 population will triple from the current 2.5 million people to 7.6 million people in 2025.

- The elderly have historically utilized a greater proportion of health care resources. In 1978, the average per capita expenditure for health care by Medicare-eligible individuals was $2,026, as compared to $764 for individuals between the ages of 19 and 64, and $286 for individuals under age 19.

Technology

There is not only an increasing demand for health care services, but the mix of services available involves more sophisticated technology that

is continually updated. While improved methods of treating patients through new technologies cannot guarantee the provision of quality health care services in all instances, it cannot be denied that expenditures for technological advances have served to improve the overall quality of health care that is available.

Resource Allocation

The United States may have reached a point in its history where it appears that sustained economic growth can no longer be maintained and limited resources will force the necessity of facing difficult choices. As witnessed by the total revamping of the methodology for payment for hospital services under Medicare, Congress has established its willingness to limit resources devoted to health care. However, we urge caution so that changes made today do not place in jeopardy the continued availability of quality health care for future generations.

A classic example of the legislative process resolving the problem of allocating resources for the availability of certain types of expensive health care services is the development of the end-stage renal disease (ESRD) program. The effect of this decision by Congress was the expansion of a specific medical technology to all of those in need of it but at a substantial cost to the federal government. When the program was initiated in 1974 it covered approximately 18,400 individuals at a cost of about $230 million. Presently the program serves over 70,000 patients at an annual budget of almost $2 billion; renal patients represent approximately 1/4 of 1% of the Medicare beneficiaries, but they consume nearly 10% of the Medicare Part B budget.

Mr. Chairman, it is just such expenses and such programs that illustrate the complex considerations that are inherent in decisions made in the name of health care cost containment. By way of example, these questions relating to individuals with a need for dialysis were decided differently in the United Kingdom where age is a primary consideration in determining eligibility for dialysis treatment.

AMA Consumer Choice Principles

The evolution of our system of payment for health care has seen workplace-based health insurance emerging as the primary means by which most Americans pay for health care services they receive. The nearly universal coverage of medical expenses by health insurance or Government health programs has insulated most Americans from consideration of the cost of medical services. Many economists have said that this is partly responsible for the continuing rise in medical care costs.

Typical government responses to this situation have been to impose limits on the supply of capital-intensive health services such as through the ill-fated health planning program. It has been AMA policy that demand for services should also be addressed. Thus competition and individual choice should be enhanced as alternatives to regulation.

To help assess and guide federal legislative proposals impacting upon the nation's health insurance system, the AMA has developed the following principles. These principles should be considered as a whole. They spell out a policy for greater individual choice and for incentives for prudent behavior by individuals. While the principles may singly state appropriate policy, it is intended that all principles be considered in reviewing consumer choice/competition legislation.

1. Employment-Based Health Insurance. The growth of employment-based group health insurance for employees and their families should continue to be encouraged through tax incentives.

2. Adequate Benefits. Each health insurance plan offered to employees should contain adequate benefits, including catastrophic coverage. Plans which do not have adequate benefits should not qualify for tax deduction as a business expense for the employer.

3. Multiple Choice of Plans. Health insurance plan options, with varying levels of coinsurance and deductibles, should be available to employees; accordingly employers, through tax incentives, should be encouraged (but not required) to offer employees a choice of several health insurance plans. Multiple options will better meet individual and family needs and encourage greater individual responsibility in utilization of medical care services.

4. Equal Contributions. Equal employer contributions should be made for health benefit plans, regardless of the plan selected by the employee.

5. Limitation on Tax Deductibility of Excessive Health Insurance Premium. A limit should be placed on the amount of health insurance premiums paid by an employer that would be tax exempt income to the employee, as with life insurance. This amount should be high enough to provide for adequate benefits and should be adjusted for inflation. In order to discourage over-insurance and "first-dollar coverage" which can cause increased demand for care, amounts paid by the employer in excess of the limit would be taxable income to employees.

6. Rebate to Employees. In order to stimulate prudent selection of health insurance by employees, employees may receive non-taxable rebates when choosing an insurance policy where the premium cost is less than the amount of the employer contribution.

7. Quality of Care. Employer health insurance plans should assure employees the free choice of sources of medical care services. Services should be of high quality. Plans should provide comparable benefits for treatment of physical and mental illness.

PENDING LEGISLATION

Mr. Chairman, there are many bills pending before the Committee that deal with the area of health care costs. Today, I will address four bills: S. 2501, S. 2502 and S. 2503, introduced by Senator Quayle, and S. 2424 introduced by Senator Kennedy.

S. 2501 - Public Health Service Act Amendments of 1984

S. 2501 has three major provisions. The first provision would amend the HMO law to require employers with 25 or more employees to offer to their employees "competitive medical plans" (CMPs) along with the currently required HMO option if the employer has a health benefits program. The second provision would preempt state laws that may restrain the development of preferred provider arrangements or organizations. Such state laws would include restrictions on insurers entering into agreements with health care providers to reimburse them at a different level than they reimburse other health care providers, and laws that prohibit issuing policies or offering group plans limiting the beneficiary's choice of health care provider to those providers having reimbursement agreements with the insurer. The third provision would require all employers with 25 or more employees to make available annual blood pressure testing to their employees.

The AMA does not believe that S. 2501 should be adopted. Concerning the requirement that employers offer competitive medical plans along with an HMO option, the AMA believes that this new provision, like the mandated HMO option, is inappropriate and should not be adopted. While pluralism in health care delivery should be fostered, undue incentives for a particular form of health care should not be provided.

The Association is particularly concerned with provisions of the bill that would preempt state laws concerning preferred provider arrangements. We believe that issues involved in formulating insurance laws are best dealt with at the state level and that states should retain

ability to develop their own laws governing PPOs in order to protect their citizens and to meet local conditions and needs.

S. 2502 Medicare Preferred Provider Arrangement Act

This bill authorizes the Secretary of HHS to enter into contracts with "insurers or other third party payors" to arrange for Medicare Part B services to eligible beneficiaries through preferred provider arrangements (PPA). These PPAs would operate in a similar manner as HMOs that only provide Part B services.

Under a contract between HHS and a PPA, the amount of payment for individual beneficiaries enrolled in the arrangement would be based at 95% of the average adjusted per capita cost that Medicare incurs for beneficiaries for Part B services. Medicare beneficiaries electing to receive care through such an arrangement would be held responsible to pay an amount up to the average actuarial value of the coinsurance and deductible amounts that would be applicable for Part B beneficiaries not participating in such an arrangement, health maintenance organization, or competitive medical plan. Preferred provider arrangements would be required minimally to provide the services of physicians (defined to mean M.D. or D.O.), laboratory, x-ray services, emergency services, and preventive services. PPAs would also be required to maintain a sufficient number of participating physicians and other health care providers to ensure that services will be available and accessible to all participating Part B beneficiaries in an appropriate and prompt manner to assure continuity and the availability and accessibility of services 24-hours per day and seven days per week when medically necessary.

Preferred provider arrangements would be required to accept enrollees up to their capacity, as determined by the Secretary, during an open enrollment period of at least 30 days each year. All Medicare beneficiaries eligible to participate in the Part B program, other than those having ESRD, would be eligible to enroll in such an arrangement. Also, self-insured employers that establish a PPA may limit membership to employees and former employees.

Mr. Chairman, The AMA maintains a policy supporting a pluralistic approach in the delivery of and payment for health care services. Coupled with this policy is a call for neutral public policy regarding competing methods of health care delivery. While S. 2502 would appear to meet this goal, we are concerned by a number of problems with the bill. These problems include its lack of specificity in definitions (including the definition for a PPA, insurer and other third party payor), the potential for skimming, the potential of unfair competition that would be fostered by the patient's perception of higher Medicare reimbursement and the fact that the PPA is identified by the Medicare program as being "preferred," and the potential for limitations on freedom of choice. We are also concerned that a PPA may fail to offer adaquate benefits, thereby leaving the Medicare beneficiary with inadaquate coverage.

The PPA concept is new and does not have widespread operational experience. In order to better determine if PPAs should be integrated into the Medicare program, we urge authorization of demonstration projects similar to those that preceeded Congressional action on including HMO coverage under Medicare.

S.2503 - Health Care Consumer Information Act

S. 2503 would require the Secretary of Health and Human Services to: (1) conduct a study of the effects of efforts underway in Minnesota, Florida, Iowa, Utah and other areas to provide hospital price data to third party payors and consumers of health care services; (2) develop methodologies for providing third party payors and consumers with price data with respect to ambulatory health care services; and (3) develop methodologies for providing consumers with information with respect to the quality of health care services. The Secretary would submit a report to Congress with respect to these studies and projects within one year. The stated intent of this bill is to provide consumer access to easily understood and relevant cost and quality data will make the health care marketplace more competitive.

While the AMA supports the availability of accurate and usable information to patients, we believe that this legislation is unnecessary. The Department of Health and Human Services already has authority to conduct studies of state programs as called for in the bill. The Association also questions the feasibility of developing methodologies for determining the quality of health care and providing consumers of health care services with such information and is concerned that consumers may be provided inadequate information to make informed health care decisions.

S. 2424 - The "Medicare Solvency and Health Care Financing Reform of 1984"

S. 2424, the "Medicare Solvency and Health Care Financing Reform Act of 1984," (introduced in the House by Representative Gephardt as H.R.

4870 and referred to as the "Kennedy-Gephardt" bill) provides for a radical restructuring of reimbursement for inpatient services for both hospital and physician services. It is not restricted to payments under Medicare and Medicaid but creates reimbursement limitations affecting each hospital's total revenues regardless of the payor source.

Background

The bill would create incentives for states to develop plans to limit total hospital revenues for all services provided to hospital inpatients. The proposal creates a punitive residual federal program, which would be effective in states failing to adopt programs meeting standards set in the bill. A state plan must meet objectives of the federal plan and be approved by the Secretary of HHS. Total hospital revenues would be capped statewide at a level that would be set if the residual federal program was in operation, and individual hospitals would have limits set on reimbursement per discharge. This amount would include both hospital and physician services. State plans would be obligated to create mechanisms to provide payment for hospital care for under-insured and uninsured individuals, plans would also have to provide an exemption from the program for health care facilities owned or controlled by or serving individuals who are predominantly members of HMOs or other "eligible" organizations.

A residual federal program would provide for a prospective payment limit on all inpatient hospital services based on a diagnosis-related group (DRG) in states without a state plan in operation. In addition, total revenues for inpatient services for each hospital would not be

allowed to exceed a predetermined limit without penalty. The bill would also substantially modify inpatient physician payment mechanisms for Medicare beneficiaries by requiring that all payments for physician services be based on DRGs and be made through the hospital in the absence of other arrangements. Assignment would be mandated for all physician services.

The bill also provides a series of "competition" proposals intended to encourage individuals to receive care through an HMO or other "qualified" plan.

Comments

The AMA has carefully studied this complex bill and we urge its rejection. The Kennedy-Gephardt bill calls for a radical restructuring of the payment mechanisms for health care delivery throughout the country without the benefit of even a single demonstration as to how such a system could work and what effects it would have on health care delivery and the health status of the population. The very fact that the bill calls for studies as to how to maintain a high quality of services while constraining the rate of increase in costs only points to the fact that the bill is "putting the cart before the horse."

The bill would result in a rationing of health care services for individuals in need of hospital care because of its arbitrary establishment of hospital revenue caps. By capping hospital revenues and imposing heavy penalties based on preset revenue and admissions limits, the bill would squeeze potential revenues per case, and hospitals would be forced to cut back on the availability of care or impose rationing to

make ends meet. The bill would establish incentives for hospitals and physicians to reduce services -- a goal that is usually tied to a reduction in the overall quality of health care services.

In addition, the AMA specifically objects to the Kennedy-Gephardt bill for the following reasons:

- The bill would inappropriately modify the Medicare program to penalize hospitals that have any increase in admissions over their previous admission average. (Medicare would allow only marginal cost reimbursement, 40% of the DRG or 50% in states with a state plan, for all admissions in excess of the number of admissions set by the hospital's base period). While the program would allow for the Secretary to take into account admissions in excess of this period that are "extraordinary and due to circumstances beyond the hospital's control," there is no leeway for full reimbursement for additional admissions where those additional admissions may indeed otherwise also be appropriate.

- The bill would mandate assignment for all physician services for Medicare beneficiaries. The concept of mandated assignment is unnecessary given the past history of Medicare assignment. Also, mandated assignment, when coupled with the DRG payment methodology and the separation of the Medicare program from other payment mechanisms, would discriminate against Medicare beneficiaries as a separate classification of hospital patient who could be a target for limited care. By mandating assignment, physicians would be discouraged from participating in Medicare, and patient access could be hindered.

- The bill creates an Advisory Committee on Health Care Technologies and Procedures that is directly tied to a system of controlled budgets and further creates the potential for rationing of health care. (The Advisory Committee would be required to examine the appropriateness of various medical interventions, the safety and efficacy of alternative therapeutic and preventive regimens, and provide standards for availability and utilization of technologies. The committee would then be empowered to "publicly report" on whether or not payments should be made for such services and the conditions and frequency of service.) The operation of this committee under the aegis of a cost containment bill might bring inappropriate budget considerations to bear in making reports on coverage for new technologies and procedures. The primary determinant of coverage should be the potential benefit to be derived from the service,

and this can best be determined with credibility and objectivity by local groups and institutions.

- States would find it difficult to develop an individual program in terms of both costs and administrative feasibility. Although the Secretary would be authorized to assist states in developing their programs, state programs would still have to meet stringent federal requirements established in the law that would set reimbursement limits for all services provided to hospitalized patients. This would require states to develop a maximum amount of payment per discharge that would account for both the costs of hospitalization and physician services. The AMA questions the feasibility and cost of developing such a payment rate. It has not been done previously for physician services, and an average cost per discharge for hospital care has only recently been determined for Medicare beneficiaries. It must also be pointed out that the DRGs determined for Medicare beneficiaries are still the subject of considerable controversy, and it is likely that many hospitals will find, after experience and the conclusion of the transition period, that the DRG payment is inadequate to provide quality care and meet their costs.

- Because of civil penalties under the Federal program, hospitals will have no incentive to expand the scope of care they provide or to attempt to market their services to a larger portion of the population. Any such expansion or extension of the hospital's population base could result in a net increase in the institution's total inpatient revenues, causing imposition of penalties.

  The federal program would also penalize hospitals for attempting to increase their population base as they would only be reimbursed at a marginal rate (60% of the allowed rate) for all discharges that are in excess of a base number of discharges determined by the hospital's previous accounting records. This penalty acts to provide a strong disincentive for a hospital to work to increase its population base and increase the availability of its services to the local community.

If enacted The Kennedy-Gephardt proposal would inevitably spawn an enormous amount of federal regulations to implement, monitor and enforce the law. Enormous resources would be required in the private sector to operate in the environment created by the bill. This complexity alone increases the risks of unintended or marginal results. The very complex nature of the proposal could also threaten the efficient delivery of

health care in this country by inappropriately diverting the resources and attention of those individuals responsible for providing health care. The AMA does not believe that the Kennedy-Gephardt proposal is a responsible approach for the future of health care delivery in America.

CONCLUSION

Mr. Chairman, decisions concerning how many health care dollars there will be for tomorrow and how they are to be directed are as much life and death decisions as any individual treatment decision that a physician may face in the course of his or her practice. We urge you to keep this fact foremost when you and other members of Congress consider the future of our nation's health care delivery system. The American Medical Association actively is pursuing avenues to hold the line on health care costs while preserving the quality of health care. We do not undertake this activity lightly.

The AMA urges this Committee and Congress to act to help assure access to the high level of quality care currently provided by our health care system. We believe that the great advances in the American people's health status has occurred because this country has devoted necessary resources to the health care sector. We believe this policy should continue. We also believe that further strides can be made by encouraging the American public to prevent illness through adoption of healthier lifestyles--such as improved diets, reduced smoking, exercise and seat belt use. The AMA is involved in a public education program to encourage such activities, and we believe that federal government also can play a larger role in encouraging such activity.

America's physicians stand ready to cooperate in our nation's continuing commitment to assure the highest possible level of health care to all Americans. We urge you to keep in mind that while expenditures for health care have greatly increased over the past 30 years, the nation and its economy as a whole have received significant benefits from these expenditures: improved health status, increased productivity, longer life expectancy, and improved quality of life.

At this time, Mr. Chairman, I would be pleased to respond to any questions that you or other members of the Committee may have.

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AMA Cost Effectiveness Activities

While the medical community has called for a freeze in physician fees, the AMA recognizes that it is not in a position singlehandedly to curtail the increase in health care expenditures. In light of this, the AMA is taking other positive actions to eliminate inappropriate health care expenditures.

National Commission on the Cost of Medical Care

The American Medical Association has taken an active role in issues relating to the cost of health care. The AMA was instrumental in the development and operation of the National Commission on the Cost of Medical Care, and has been working to implement recommendations from this Commission relating to strengthening price consciousness, private sector cost containment initiatives, working through the regulatory process, cost containment measures within medical practice, issues relating to supply and distribution of health care providers, research guidelines, and consumer and patient information. An important element of this Commission's report emphasized the importance of changing incentives within the health care delivery system to enhance competition. The 48 recommendations of the Commission on the Cost of Medical Care, issued in 1978, have served as a starting point for AMA activity related to cost-effectiveness.

Cost-Effectiveness Publications

For the past four years, the AMA has published an annual Cost Effectiveness Plan. The 1984 Plan documents the Association's on-going efforts to stem inappropriate growth of medical care costs. This Plan details numerous activities of the AMA to meet its commitments concerning limiting health care costs that are found to be inappropriate.

The American Medical Association fully recognizes that an important element in the growth of cost effectiveness activities is the publication of information about on-going efforts to deliver cost effective health care. To this end, the AMA is in its third year of publishing the AMA Cost Effectiveness Bulletin. This Bulletin is designed to provide cost effectiveness information to state medical associations, metropolitan and county medical societies, and national medical specialty societies. In addition, this Bulletin is generally available to hospitals, hospital associations, and other interested parties. The Bulletin publicizes information on AMA cost effectiveness activities and also publishes information related to the activities of other organized groups working to this end.

Cost Effectiveness Network

One of the more promising activities that the AMA is involved in concerning cost effectiveness is "cost effectiveness network." This

network is co-sponsored by the AMA, the American Hospital Association, and the Federation of American Hospitals and is aimed at involving hospital medical staff and administrators in collaborative cost effectiveness activities. The program consists of more than 80 hospitals throughout the country that will take part in experiments to evaluate a variety of cost effectiveness projects.

The first project that was implemented within this network is a protocol for holding economic grand rounds. (An implementation guide for economic grand rounds has been published and is generally available.) The purpose of this program was to enhance physician awareness of the cost of the services they order by use of the grand rounds teaching forum. This program had essentially four operational goals:

- to encourage practicing physicians to reflect on their practice patterns in the context of cost effectiveness;
- to reinforce clinical behavior which is directed toward the cost effective delivery of high quality medical care;
- to change physician behavior where appropriate to reflect more cost effective delivery of high quality care;
- to stimulate additional activities geared to foster the cost effective delivery of medical care.

As this program and other programs developed through the cost effectiveness network prove beneficial, it is hoped that similar programs can be launched in other hospitals and that a major impact will be felt throughout the health care delivery system. A new program that is now being analyzed through the cost effectiveness network is a study designed to improve the efficiency of the utilization of respiratory care services.

Health Care Coalitions

Health care coalitions have had success in such diverse activities as case management and utilization review, expanding physician and employer knowledge about employee limitations in particular work places, redesigning corporate benefits to encourage more cost effective ways to use the health care delivery system, increasing opportunities to develop the most cost effective and equitable forms of provider payments, drafting and supporting legislation to reform medical liability laws, developing health education programs in the workplace, collecting and analyzing data on the utilization of services, and community health planning.

Conferences on Costs

The AMA has undertaken other activities to emphasize the importance of cost effectiveness. In 1982, the AMA cosponsored the National

Conference on Utilization of Health Services with the American Hospital Association and the Blue Cross and Blue Shield Associations. This program focused on improving the efficient use of health services through early discharge programs, alternatives to inpatient care, and effective utilization review. Because of the success of this conference, the AMA has expanded its program on utilization of health services. The AMA also sponsors annual conferences, the National Medical Specialty Society Cost Effectiveness Conference, to aid medical specialty societies in the development of cost effectiveness projects that are geared to their own memberships.

Medical Education and Practice

The groundwork for cost effective medical practice must begin in medical school. To this end, a recommendation from the National Commission on the Cost of Medical Care was that medical, dental and osteopathic schools should expose students to the economics of the care they deliver. Since this recommendation was adopted by the AMA House of Delegates in 1978, most medical schools have integrated cost containment as an element of medical education. As of 1981, the subject of cost containment was taught in 93 of the 124 United States medical schools, and the issue was covered in almost every state.

In addition to stressing the value of cost effectiveness in medical education, the AMA also is stressing the value of prevention as a means to achieve cost effective health care delivery in this country. The AMA sponsored a national conference on the issue of prevention of disabling injury. The conference concentrated on developing concensus definitions of injury and disability, prevention of injuries in various settings, and the physician's role in preventing disability due to alcohol-related problems.

Health Policy Agenda

The American Medical Association realizes that Congress needs assistance from the public in making any future determinations on how health care services should be delivered in this country in the future. To this end, the American Medical Association has taken the first step by initiating a project to create a future health policy agenda for the American people. This project is designed to develop a philosophical and conceptual framework as the basis for specific action plans and proposals that are to be responsive to the particular social, economic, scientific, educational and political circumstances facing health care decisions. This activity involves approximately 150 organizations, including representatives of medicine, government, nursing, the elderly, business, the hospital industry, the public, and health care insurors. By this broad-based organizational body, we hope to be able to present Congress with viable principles and working programs for the development of a future health policy agenda that will assure the availability of high quality health care services for the American people.

The first phase of this project, the development of principles to help guide future health care decisions recently has been completed. A copy of these principles as they were presented to the AMA's House of Delegates will be submitted for the record. The next phase of this project will come to grips with the development of policies to imnplement these principles. The AMA expects that the Health Policy Agenda project will look to the cost of providing health care services, and we expect that this body will come to grips with the same issues confronting Congress.

Senator QUAYLE. Thank you very much.

Dr. Schenken, I know the AMA indicated they support competition between physicians and feel that competition is helpful. How do we go about in an unintrusive and unregulated way—let me rephrase that—on a voluntary way to get more information to the consumer on price and quality information. There is just a real thirst for that out there, and I wonder what kind of thoughts you have on that. If we are going to have competition, we have to know what we are competing for.

Dr. SCHENKEN. The AMA has been in favor of appropriate meaningful information as long as I have been with them. I think you have heard today that in addition to the massive amount of information the AMA puts out that the coalitions that are developing which AMA and local and State medical associations are part of, and you mentioned several States, Iowa, Minnesota, and so on, everybody is beginning to put out information.

What is of concern to the profession is that the information be accurate, meaningful, and lead to the proper interpretation and the proper actions on the part of the recipients of that information. As long as that can be guaranteed, we would be in favor of disseminating this, but we don't want a situation where the information leads to erroneous conclusions such as is contained, I believe, in your opening statement in the Congressional Record concerning the physician that had the high death rate and it turned out it was because he took care of such sick patients. We want it to be accurate, we want it to be interpretable, and we want it to lead to the right conclusions.

Senator QUAYLE. I am curious that you refer to my comments on looking at Minnesota and Iowa and Utah because that is what one of our bills, S. 2503, wants HHS to look at what they have done there to come up with recommendations on how we can get more information, yet AMA opposes that. It is just simply a study of this and you are on record in opposition to it. Maybe you want to take that back to the group, because I don't think it is really out of line with what you are saying.

Dr. SCHENKEN. Could I explain that?

Senator QUAYLE. Sure.

Dr. SCHENKEN. I don't think the AMA is opposed at all to the objectives within that bill, but we have seen again and again situations in which the information that has been distributed out of HHS has been inaccurate and misleading and we are afraid of it.

Senator QUAYLE. Well, we are just asking HHS to make recommendations from a study on how—and we cite these particular

groups—on how we might go about it. We are not asking or giving authority to HHS or encouraging them to do that.

I think, from your statement, that you do support competition among physicians, and we do want to have that competition, but that issue of quality and cost and that information—I don't have an answer for it. That is why it is very vague in the legislation, but I was really quite chagrined that the AMA just outright opposed it, to be quite honest.

Dr. SCHENKEN. We would like to work with you to try to reconcile those differences.

Senator QUAYLE. Great.

Mr. Bromberg, do you want to comment on that?

Mr. BROMBERG. I just wanted to add that we do support your bill, but I can understand the witness' reticence because there is a version of your bill floating around the House side which goes one step further and mandates the Federal bureaucracy give technical assistance and implement and doesn't take it step by step. That is why we support your version of that proposal.

Senator QUAYLE. Maybe we can get that clarified with the AMA.

Mr. MCMAHON. Mr. Chairman, there is always a temptation to solve a problem that is presumed to exist but doesn't. One of our hesitancies in the American Hospital Association about statistics is that people don't make decisions on the basis of statistics. Let's take my employees, and they are not all health care professionals. I have a lot of clerical and housekeeping and production people as well.

In the 900 employees in Chicago of the American Hospital Association, something over 500 have made a choice of six HMO's and one PPO type of arrangement. I don't have any requests from them for more information. The word of mouth is very effective because it is community based, depending on where they live.

The rest of them have stayed with Blue Cross, now with substantial cost sharing. They know how to select doctors and how to select hospitals, too. So, when I hear about the uninformed American public needs more information, I am not so sure, because I am seeing people make good decisions on the basis of their neighbor's experience and what else they are hearing in the doctors they talk to. As far as my 900 people go, statistics on morbidity when you are trying to compare tertiary care hospitals, the Cook County hospital, some suburban hospitals, and some inner city hospitals dealing with indigent individuals, it wouldn't make any sense.

Senator QUAYLE. There is certainly a question on whether you are just going to use statistics and all statistics are going to have the same reflection. When I first brought this up, an individual brought up to me a problem in Cleveland where this cardiologist had a failure rate or 80 percent and on the surface just like that that was pretty bad, but then we found out with further examination that all the patients that he took were almost no-win type situations and a 20-percent success rate was fantastic.

The question is how do you communicate that to the consumer. That is what we are searching for. I think that is what I want to do. Believe me, I fought tooth and nail the imposition of a consumer protection agency many years ago and I don't want to get

into that business again and I am not talking about that, but I do believe that we have to look at this information and how we can sanitize it in a way that is going to be helpful.

Did you have a further comment?

Mr. BROMBERG. I would just like to add that the best way to get that information to the consumer, whether the consumer is an individual or a labor union or a business, is through the pocketbook and the knowledge that under a preferred provider system or an HMO or some other system that going to a high-priced provider, whether it is for right reasons or wrong reasons might cost a little more, will give the strongest incentive you can find to the consumers to get that information, and they will get it. When a doctor or a hospital is left off that preferred list, people will want to know why and they will know that to get on that list, they have to not only disclose their price but get it in line, and you will, for the first time, have some price competition. That would be a lot more effective than simple disclosure.

Senator QUAYLE. Let me shift gears a little bit to the medicare waivers and how they have actually worked with the various all-payers State regulated basis versus the competitive States. Have the medicare waivers, in effect, worked? Have they been helpful to allow these States—Mr. Helms brought up the example that HCFA thought that New Jersey, for example, was actually costing more under their all-payers system than if they had been part of just the DRG and let the remainder be competitive.

I wonder if either one of you has any thoughts on that.

Mr. BROMBERG. Let me try to do that briefly. First, I don't know the answer to your question. I have suspicions, but I don't know. Second, because I don't know, we have asked the Department to very carefully scrutinize it because I am concerned. We start off with the fact that the four waiver States are among the most costly in the country. Their base costs per admission are very high, much higher, for example, than Indiana, maybe 50 percent higher. For that reason, it is relatively easy to listen to them claim savings based on holding down their rate of increase, because a 10-percent rate of increase on $4,000 is a lot more money than a 10-percent increase on the $3,000 it might cost in Indiana.

Second, we have some concerns that we need to get a better public policy on how to treat the indigent, but we don't want to see waivers being used as a way to get more money out of medicare to the detriment of the other 46 States that don't have waivers to the hospitals in those States even for a good cause like paying for the indigent. We think we need a better Federal policy on that issue, not one State versus another.

So, there are geographic problems and there are base dollar problems. We have been involved in trying to get the administration to make sure that medicare was not paying more than it otherwise would have, because that is what the statute requires. Unless that statute is enforced, the penalty is falling on the other 46 States. We have made it clear that there might be reasons such as higher case mix, higher education costs, and other reasons, but we don't know and no one seems to know, and that is why we wanted the Government to take a much closer look at it.

We do know, however, that claims of these four States that they

have done a great job in holding down cost, according to the studies we read, lead us to believe that the statistical difference is not significant and that part of this may be the fact that they start with a much higher base and that they have so much to begin with that they don't need as great an increase.

Mr. MCMAHON. Mr. Chairman, we continue to look at that with our mass of statistics, and we can't make heads or tails of it either, in part because the world is changing so rapidly and they start off, as Mr. Bromberg said, with a high base. What is significant, particularly as you look at the first quarter of this year, and again, we don't find much regional difference, but we don't have enough to get to be comfortable with statistics and the statistical validity on a State-by-State sample with our 2,400 hospitals in the monthly survey. What we do see is such marked reductions in inpatient costs and hospital costs and costs per case across the country that it does look as though if the rest of the country isn't below, it certainly is no higher than the experience in the waivered States. As I said, 5.6 percent in the first quarter of this year.

Senator QUAYLE. OK. Thank you all very much.

Dr. SCHENKEN. Senator, could I have 10 or 20 more seconds to make one more comment on statistics and information?

I am from Nebraska, and some years ago I looked at medicare costs in Nebraska and found—don't hold me to the exact numbers—Nebraska medicare patients spent over 400 patient-days per thousand in the hospital, which is high. Their length of stay was below the national average. Their cost per day was much below. The average cost per admission was way below, and the total cost to the Government to take care of all medicare-aged citizens in Nebraska was way below the national average. Nebraska women live 5 years longer than the national average; Nebraska men live 1 year longer.

Now, I am not here to tell you that any of those statistics are related, but it shows you the possible misvariations and interpretations of statistics if you just look at them on a raw basis.

Senator QUAYLE. OK. Thank you very much, gentlemen.

The final panel is David Kinzer and William Hutton.

Mr. Kinzer, you may proceed.

STATEMENT OF DAVID M. KINZER, PRESIDENT, MASSACHUSETTS HOSPITAL ASSOCIATION, BOSTON, MA

Mr. KINZER. Thank you, Mr. Chairman.

I am here today to relate to you the experience of an all-payers State. It takes a while, and somebody was talking about statistics, it takes a while to get the verdict in, but we are beginning to see some results on the plus side.

I am also speaking relating to the experience of three other waivered States, Maryland, New Jersey, and New York. We are meeting regularly to talk about our experience and, in the process, to try to learn how to perfect them. In these meetings, and we had one in New York last week, we include the health insurance industry and the Blue Cross and the State officials of the four States because all of these systems are different. They are all complex, and

they have one common theme which is what would be mandated by the legislation before you.

I have eight points to make about our experience to date, and I will try to go through them as quickly as possible. The first one is that we have, and this gets into the numbers, we have been successful in reducing our rate of increase. In the first fiscal year of our program, we were down to 6.8 percent increase compared to a national average of 12.3. The other three States, and it is in my testimony, can validate increase levels, and we did start from a higher base, that are lower than the national average.

Our Blue Cross Plan reported to me last week that they are now coming into their customers with premium increases in single digit numbers. What started our program in the first place were premium increases in the range of 20 to 40 percent. So, it is down; there is containment there.

My second point is that the prime reason for effective cost control is we are driven, and this was stated by other witnesses, by one set of incentives. We built our waivered system on a Blue Cross contract that rewarded hospitals for controlling length of stay, limiting admissions, and reducing the upward trend in use of ancillary services. After we put this in the Blue Cross contract, all the other payers wanted the same incentives, and it does make sense because we had a system, and this is common to many unregulated States, we had a system where for one payer you rewarded them for keeping the patient longer, for another you rewarded for admitting less, and for a third, you rewarded for increasing utilization of ancillaries. Then, the Government was paying costs on top of that and you were rewarded for increasing your costs. The result of that was no incentive at all.

One of the real values, and I emphasize this, of an allpayers system is that you can install one set of incentives on allpayers and it does work.

One of the issues that is constantly raised, and it was raised by my own membership, about coming into a drastic change in a payment system was that this would reduce or diminish quality of care. I have not been able, after 20 months, to document any diminution in quality. It is a very difficult thing to do anyway, and I would only say that in terms of our experience in Massachusetts, I think it is beginning to happen this year, the result of reductions in revenue as far as our physicians and nurses and other professionals in the hospitals is, making choices about what services not to provide if they are available in a neighboring institution. They are not going to diminish quality; they are going to refuse to do it.

So, I think the concern about this, the ratcheting down of total revenue in the hospital, is going to have a result that is not going to be, for the services offered, a dimunition in quality. Instead, it is going to result, over time, in a transition of more services being concentrated, the specialized things, in fewer hospitals.

My fourth point is that we have done better, the four waivered States, than any other States in the country, in maintaining open access and this is the free care, charity care, thing. The way we have been able to do it was through regulation. We created pools of money under medicaid and through a requirement that all payers

share in free care across the system. We have been able to keep an open system. One example that is extreme in our area is Boston City Hospital which has about 40 percent free care and where we have been able, through the design of large, after 372, to get substantial subsidy from the payment pool to support this effort.

The fifth point, and this is a conservative point, and our system has a lot of conservative support up our way, the boards of our hospitals like it because it permits them to decide at the hospital level how they are going to spend their money. We maintain discretion at the hospital level in this system.

I see that my red light is on, Mr. Chairman, and I wasn't able to finish my eight points.

Senator QUAYLE. But your eight points will be put in the record.

[The prepared statement of Mr. Kinzer (with attachment), follows:]

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
HEARING OF JUNE 21, 1984
Testimony on S-4870
David M. Kinzer

My name is David Kinzer. I am president of the Massachusetts Hospital Association. Ours is one of the four states operating under federally waivered all-payer hospital cost-control system, the kind of system proposed in the legislation before you. My purpose is to relate to you the positives of the all-payer approach, based on actual Massachusetts experience over nearly 20 months. My testimony also reflects continuing dialogues we have been having with representatives of the other three eastern waivered states which are now under all-payer control systems. There was a meeting as recently as last week in New York City of representatives of Blue Cross, the health insurance industry, and state government as well as the hospital associations from the four states. The purpose of these meetings is to share ideas on how to make our systems, all of them different and all imperfect, work more effectively.

I feel comfortable in saying that there is strong and growing support in our four states for all-payer, with the caveat that we still have many rough spots to iron out. The support isn't just from our hospitals, but from business groups, state government officials, and private third-party purchasers as well.

I am <u>not</u> here to discuss the particulars of the Kennedy-Gephardt

proposal, except to make the general comment that it seems to have its rough spots, too, some of which might be eliminated if its provisions can be related more clearly to the practical experience with all-payer in the four states.

Instead, I will attempt to explain why support of the all-payer approach is growing in our four states and in several other states as well.

It is stating the obvious that nobody, including my hospital constituency, wants more regulation or likes it after it is imposed. But it also seems obvious to me that more health regulation in our country is unavoidable.

I can cite several reasons for this. The most important is that, given present public expectations on medical care as a "right," marketplace forces cannot be permitted to be totally controlling on what happens to our health-care system. In other words, price competition tends to put at a disadvantage those hospitals that are most responsive to the public demand for open access to their services. Another reason is that the decline and fall of retrospective cost reimbursement ordains the development of publicly credible designs for the distribution of a limited supply of money. This scenario is already playing out with DRGs under Medicare. Some don't like to call

this regulation, but the distinction between national price fixing on an elaborate scale and regulation seems mostly one of semantics. A third reason more regulation confronts us as a reality is that technological advances in medicine, with their capacity to generate new demand and significantly more expense, are forcing us to address the issue of how to limit, or control the distribution of these new "medical miracles." This problem had a recent expression in my home state in the public discussions of which hospitals should be permitted to perform liver transplants. It seems significant that, though the Task Force that studied this issue agreed that the number of procedures permitted in hospitals should be limited, it also said that transplants should not be denied a patient because of his or her incapacity to pay for them.

If we accept these three main points, as they clearly have been in the Commonwealth of Massachusetts, then the question becomes not one of whether to regulate, but how. What is workable, effective, and fair? No state has come up with a definitive answer to this question as yet. Neither has the federal government. But in the waivered states, we now have conscientious efforts to produce something acceptable in an arena that has always been highly controversial. The country needs this kind of experimentation and needs to allow time for these experiments to prove out. Also, given the many unknowns in health regulation, it seems to me a strong case can be made for diversity of

approach of a kind that would be permitted under S-4870. And, given the apparent need to define cost-containment targets nationally, there are some strong political arguments for giving the separate state governments, in collaboration with health leaders in the voluntary sector, large discretion on how it should be done.

Based on current experience in Massachusetts, and relating to some of the experience in the other three waivered states, I can identify eight "positives" in our all-payer experience.

1. All-payer is putting the brakes on hospital expenditure increases in all four waivered states. Our Massachusetts Rate Setting Commission reports that, in the first fiscal year under our new law, the aggregate costs of our hospital system increased by 6.8 percent, compared to a national average of 12.3 percent. More details on our economic performance are contained in the attached memorandum from Robert Griffin, our RSC chairman. New York has just advised me that their record for the first fiscal year under their waiver, based on prelimimary findings, is an 8.1 percent increase. Maryland, which has had an operational all-payer system longer than any other state, reports that under its system it has been able to reduce its average cost per admission from 20.5 percent above the national average (1977) to 5.3 percent above (1983). New Jersey reports that its hospital costs, measured on both

a per admission and per day basis, have increased more slowly than the national average since its new system was implemented in 1980. In my own state, Blue Cross is now able to tell many of its customers that its premium increases are in single-digit numbers. What had created the political pressure for our Chapter 372 control system were premium increases in the range of 20 to 40 percent.

2. A prime reason all-payer is an effective cost-control system is that the hospital is driven by cost control incentives that are uniform. Our Massachusetts system applies to all payers, governmental and voluntary, cost control incentives we had negotiated in a Blue Cross contract. These incentives reward hospitals that can reduce admissions, length of stay, and contain the ever-upward utilization of ancillary services. Before this system went into effect, our hospitals had to deal with a perverse situation under which one payer rewarded increased admissions, another increased length of stay, while yet another penalized both, with governmental payors in the position of guaranteeing payment for increases in cost. The result of this was a neutralization of all efforts in cost control. As soon as the same incentives for conservative hospital use were put into place, the results began to show, as indicated above.

3. None of the hospital associations in the four waivered states has been able to document any diminution of quality of care

in their hospitals resulting from controls on their total revenue or costs. Critics of regulation, including opponents of this legislation, cite threats to quality of care as a prime reason for their opposition. I heard a lot of this from my own members about the time our Chapter 372 was being implemented. My response to this was to ask them to give me specific, documentable examples of this as soon as they surface so that I could use them in public forums to support enrichment of hospital payments. So far I have not received any usable examples. There are a couple of reasons for this. One is that "quality" is not well defined in our hospital world, and hospital people who think their hospital's isn't what it should be usually don't want to admit this in public. Another reason relates to my own sense of respect for the physicians and other professionals in our hospitals. Mostly, I don't think they will knowingly reduce the "quality" of their services even if pressured to do so by hospital management. Instead, I am convinced we will see over time hospitals, with the support of their medical staffs, jettisoning services they don't feel are up to standards or are not well utilized or both. This kind of response won't hurt anybody if the same services continue to be available in adequate quality and quantity in a neighboring hospital. Only time can tell on this. On this subject, one important caveat. There are limits currently undefined, on how much hospital revenues can be cut without damage to the patient care. We have already seen these limits exceeded in some of our state mental hospitals.

4. The four waivered states, through regulation, are doing better in providing open access for health care to the poor than most unregulated states. Our payment systems permit extra support for hospitals, expecially inner-city hospitals, that deliver high volumes of "free care." Generally, in the four states, these hospitals are in a healthier financial condition than before the waivers were granted. In varying degrees, the four states under their waiver are able to force a more or less equal sharing of the costs of the charitable caseload among all-payors, private and public. This is in marked contrast to what is happening now in states that have no regulation and where competitive motivations prevail. There is no competition in these areas for the "free-care" caseload, nor for the usually under-reimbursed Medicaid caseload either, with the result that the so-called public charity hospitals are being filled to overflowing. I think now particularly of the situation in Chicago, Atlanta, St. Louis, and Dallas.

5. Global budget limitations for the hospital, as set annually in three of the all-payer systems, have the conservative appeal of keeping major decision-making at the hospital board level. It says something about our Massachusetts cost-control law that hospital boards mostly seem to like it. Over the years, I heard many expressions of frustration from these boards about the perverse incentives in our payment system

that seemed to reward extravagance and inefficiency. Now that our hospitals have finite annual limitations on their aggregate revenues that are defined in advance, our hospital boards feel they are better able to exercise their fiduciary responsibilities. They know how much income their hospital will get in the year ahead and they, not the regulators, decide how it would be spent. So far the results in our state have been a lot of hospital-by-hospital belt tightening, but no hospitals that are close to insolvency. At least not yet. There are some hospitals that seem headed towards this kind of trouble, some through no fault of their management. But I cannot yet report any economic problems of crisis proportions resulting from our waivered system. Based on my recent inputs, the same can be said about the situation in the other three waivered states.

6. The cost-shifting problem, a major cause of concern among private sector purchasers of care, has been effectively addressed through the all-payer approach. The pressure for all-payer in many of the states that don't have federally waivered systems is coming mostly from private sector purchasers of care. Without any controls on hospital charges, they fear that more of what government does not pay for or pays for inadequately will be shifted over to them. These fears apply not just to Medicaid which pays less than the costs in many

states, but to Medicare as well, now that DRGs are in force and in a budget neutrality mode. One feature of the all-payer approach in our four waivered states is that the system presupposes government paying its fair share of the costs of operating our hospital system. When government tries to fudge on this commitment, as happened recently in our state, the private payers stand together with the hospitals in pressing politically for a "fair share" approach. Over any extended time span, all-payer will stand or fall on the question of whether government is willing to pay its appropriate share of hospital costs, based on that proportion of service that is delivered to government-sponsored patients. Also, these payment systems won't survive if we continue much further on a trend line of state and federal abridgement of eligibility standards under Medicaid, which has substantially increased the system's "free-care" burden even while the economy continues to improve. One provision in S-4870 that is appealing to hospitals is the requirement that states abide by certain standards of coverage and payment under Medicaid.

7. In some of the all-payer states, control of costs has become a cooperative venture by all major concerned parties rather than a strictly adversarial proceeding. Our Massachusetts hospital cost-control law is the creation of a coalition that now consists of representatives of business, labor, the health insurance industry, Blue Cross, our state Medical and hospital

associations and three agencies of state government. This coalition meets regularly under a broad commitment to try to make our law work fairly and effectively. So far, the spirit of compromise has prevailed, even though some members of the coalition are natural adversaries. From a strictly hospital perspective, one gratifying result of this effort is that other parties in our coalition don't automatically blame hospitals for all of their cost increases. There is growing recognition of a need to have more risk-sharing on the consumer side and much stronger educational efforts in the areas of prevention and health maintenance. I view our coalition as a source of support for hospitals in carrying out their social mission, and not as a liability.

8. In Massachusetts and, in varying degrees, in the other three waivered states, all-payer has had a stabilizing impact on the health-care delivery and financing systems. This may sound like New England conservatism, but a lot of us in Massachusetts prefer what we have to what is now happening in many states where there is no overall economic regulation of hospitals and where competitive forces prevail. As already noted, we are doing better in dealing with the problems of uncompensated care than are the states in unregulated situations. In many areas, intensified inter-hospital competition driven by concerns about economic survival is most threatening to the hospitals that customarily have given the most free care. It is

also most threatening to some of our very best teaching and referral hospitals. With their high costs, they are the losers in a price competitive system.

We also note that where there is uncontrolled price competition between Blue Cross and other health insurers, the trend is to isolate the high risks into ever-more-narrow underwriting bases. In some states, preferred provider organizations seem to be putting the high cost tertiary care centers at risk. In these same areas, major group purchasers of care are showing increasing resistance to any subsidization of groups that are generally high risk. To us, all of this seems very disruptive. In our system, we have been able to define the competitive relationship between Blue Cross and the commercial health insurance industry. In the process, we have succeeded in maintaining the competitive status of private health insurance when it was seriously threatened by what was generally considered to be an outsized Blue Cross discount. Also, through our coalition and as earlier noted, we have succeeded in defining a new "partnership" relationship between the private sector and government which has already had some constructive results. It is merely stating reality, though, that none of this could have been accomplished without a law and regulation.

# # # # # #

DMK:MRH

The Commonwealth of Massachusetts
Executive Office of Human Services
Rate Setting Commission
One Ashburton Place, Boston, Mass. 02108

ROBERT J. GRIFFIN
Chairman
DAVID S. TELEGEN
Commissioner
KATHARINE M. PELL
Commissioner

AREA CODE (617)
727-1150

Memorandum

To: L.A. Orsini

From: Robert J. Griffin

Date: June 13, 1984

Subject: Report on the Experience of the Massachusetts Cost Control Program (C. 372)

The purpose of this memorandum is to present a simple compilation of data describing the experience of the Massachusetts hospital system under C. 372. I believe it tells a story of success.

In FY 1983 payments for hospital services (i.e., net patient service revenues for non-municipal hospitals) increased only 7.8 percent. (See Table 1). This compares with 13.5 percent in FY 1982 for Massachusetts and 12.7 percent nationwide in FY 1983. At the same time, costs increases were held to 6.8 percent, compared to 13.0 in FY 1982 for Massachusetts and 12.3 percent nationwide in FY 1983.

All payors benefitted from this success. Medicare payments for instance increased an estimated 9.3 percent compared to 13.8 percent nationwide ("Facts About Massachusetts Hospitals", Massachusetts Hospital Association).

It appears that this success is continuing in FY 1984. Approved charge levels (i.e., gross patient service revenue) are up approximately 8 percent and total payments are expected to increase only about 7 percent.

Tables 2 and 3 provide additional detail regarding the financial performance of Massachusetts hospitals. The financial condition of the industry has improved, and would have improved further if non-operating revenue had not declined.

One of the reasons for the success is that hospitals have begun to react to the utilization incentives of the program. For example, in FY 1983 patient days declined 2.8 percent, compared to 1.4 percent nationwide. Average Length of Stay declined 3.1 percent. These declines may be larger this year; a comparison of mid-year FY 1983 data with the end-of-year data indicated an accelerating decline. Also, growth of ancillary utilization is declining and there appears to be a shift from inpatient toward outpatient. (See Table 4).

RJG/JDC/crb
Attachments

Table 1

5/22/84

HA-29 5/22/84

Financial and Utilization Performance
Percentage Change in Non-Municipal Hospitals

	1980-1981	1981-1982	1982-1983
Basis of Payment			
Mass.	18.0[a]	13.5[b]	10.5[b]
Net Revenues			
Mass.	N/A	13.5[c]	7.8[c]
U.S.	18.7	17.5	12.7
Costs			
Mass.	18.0[a]	13.0[d]	6.a[d]
U.S.	18.7	16.9	12.3
Patient Days			
Mass.	-	(.35)[b]	(2.83)[b]
U.S.	-	(.35)	(1.4)
Admissions			
Mass.	-	.50[b]	.34[b]
U.S.	-	.05	.10

SOURCES:

All U.S. Data - AHA Trends for the period 10-1 - 9/30

[a]1981 HA-28i Preliminary Settlement

[b]Blue Cross MAC Reports

[c]RSC-403 Schedule V, Col. 2, line 33

[d]RSC-403 Schedule IX, Col, 12, line 94

Prepared by Blue Cross of Massachusetts

Table 2

Financial Performance of Massachusetts Acute Hospitals
Percentage Change in 76* Non-Municipal Hospitals

	81-82	82-83
Net Patient Service Revenue	12.8	7.7
Other Operating Revenue	(3.1)	9.4
Non-Operating Revenue	12.4	(24.4)
Total Revenue	11.2	7.0
Total Operating Expense	11.9	6.3
Excess of Revenue Over Expense	(15.4)	39.7

*There is a total of 96 non-Municipal hospitals. Hospitals which are missing were excluded because of incomplete data.

SOURCE: RSC-403

Analysis by Nancy Doigin, 5/29/84

6/11/84

Table 3

Revenue and Expenses, 1981 to 1983

	'81	'82	'83
Total Revenue as % of Expense	102.7	102.0	102.7
Operating Revenue as % of Expense	100.1	99.4	100.9
% of hospitals with Total Revenue Exceeding Expense	75.0	81.6	77.6
% of Hospitals With Operating Revenue Exceeding Expense	53.9	50.0	60.5
Operating Revenue Less Expense			
25th percentile	-218,499	-361,000	-231,477
Mean	23,127	- 1,000	143,051
75th Percentile	182,845	187,000	348,324

SOURCE: RSC-403: 76 Non-Municipal hospitals

Analysis by Nancy Dolgin, 5/29/84

6/11/84

Table 4

Ancillary Utilization Performance
Percentage Change for 86 Acute Hospitals*

	81-2	82-3
Diagnostic Radiology - Inpatient	2.4	(.3)
Diagnostic Radiology - Outpatient	.8	(.5)
Laboratory - Inpatient	1.9	(.9)
Laboratory - Outpatient	5.7	3.0

SOURCE: Initial 1984 MAC Reports

(1983 data is 8 months actual and 4 months projected)

Analysis by Jonathan Axon, 1/84

6/11/84

Senator QUAYLE. Thank you very much, Mr. Kinzer.
Mr. Hutton, you may proceed.

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON, DC

Mr. HUTTON. Thank you.

Mr. Chairman, I am Bill Hutton, the executive director of the National Council of Senior Citizens for the past 23 years. We have some 4.5 million older people in something like 4,500 independent older people's clubs, State councils, area councils, et cetera.

Our older Americans, who live on reduced incomes in retirement, are very seriously concerned about the spiraling cost of medical care. They express extreme frustration at the ever increasing medical care bills that they have to pay in spite of having what is called medicare coverage.

They are also very fearful that congressional action to forestall medicare's threatened insolvency will make them much worse off than they are today.

To slow the rising cost of medical care, the National Council advocates comprehensive reform toward the goal of cost effectiveness in the entire health care system for the benefit of all the citizens. We believe that the Medicare Solvency and Health Care Financing Reform Act of 1984, cosponsored by Senator Kennedy and Congressman Gephardt whom you heard today, can achieve this goal. Nothing else has come anywhere close, absolutely nothing.

The bill has two major objectives, the solvency of medicare and across-the-board restraint of rising medical costs. We believe that the Kennedy-Gephardt bill is designed to achieve that effective and comprehensive cost containment in both the short term and long term without cutting medicare benefits or increasing taxes.

Frankly, we believe that nearly all of the competition plans which have been offered to date seem to increase the consumer's financial burden or encourage competition on the basis of price. What is missing is competition among health-care providers to offer the best care in the most appropriate setting for the lowest cost. Health-care competition alone is not health-care-cost containment. It doesn't assure that providers will operate in a cost-effective manner, that they will assume financial risk for their actions, or that they will have incentives to save money.

The national council does not oppose PPO's and CMP's in principle. However, we do not regard them as singular cost-containment measures. PPO's, for example, may have a short-term dampening effect on medical inflation because some prices are discounted. To look at this artificially-produced effect as proof that we do not need regulation or system reform would be a big mistake. Discounting the price of health care is not, nor is it a substitute for, containing the cost of health care through provider efficiency and incentives.

We believe, Mr. Chairman, that long-term, effective cost containment can only be achieved through comprehensive reform of payment and delivery of health services, and that is why we support the Kennedy-Gephardt bill.

I would appreciate it if you would put my entire testimony in the record. Thank you.

[The prepared statement of Mr. Hutton follows:]

Competition as a Method of Health Care Cost Containment

Statement by

William R. Hutton, Executive Director
National Council of Senior Citizens
925 15th Street, N.W.
Washington, D.C. 20005

before the

U.S. Senate Committee on Labor and Human Resources

June 21, 1984

Mr. Chairman, I am William R. Hutton, Executive Director of the National Council of Senior Citizens representing over 4.5 million older persons through 4,500 clubs and state and area councils throughout the country. NCSC is seriously concerned about the spiraling cost of medical care. Our members, who live on reduced incomes in retirement, express extreme frustration at the ever-increasing medical bills they must pay in spite of having what is called Medicare "coverage." They also are fearful that Congressional action to forestall Medicare's threatened insolvency will make them worse off than they are today.

The costs of energy, rents, health care, food, clothing -- even telephone bills -- are going up tremendously. But the inflation in health care remains far greater than the cost of most other consumer goods. Since the elderly need more health service than any other population group, the price of hospital care, physician services, prescription drugs, dental care and many other services is seriously eroding their incomes.

To make matters worse, the country's chief health policy-maker, President Reagan, campaigned with the American Medical Association in the 1960s to fight enactment of Medicare, calling it "socialized medicine." Now as doctors depend on Medicare for large percentages of their incomes, they fight Medicare cutbacks that would reduce their incomes, but encourage increased beneficiaries' costs and workers' taxes to assure the program's solvency. President Reagan still supports the AMA positions as we have seen through three fiscal years of his Federal budget policy.

The rising cost of medical care has an impact not only on Medicare and its beneficiaries, but also on poor people, workers, insurers, employers, Federal and state governments, and many others. The National Council of Senior Citizens, therefore, advocates solutions which call for comprehensive reforms toward the goal of cost effectiveness in the entire health care system for the benefit of all citizens.

We believe that legislation currently before the Congress can achieve this goal. It is the Medicare Solvency and Health Care Financing Reform Act of 1984, co-sponsored by Senator Edward Kennedy (S. 2424) and Representative Richard Gephardt (H.R. 4870). This bill has two major objectives:

1. The solvency of Medicare without burdening workers with increased payroll or income taxes and without burdening the elderly with reduced benefits or higher cost-sharing levels.

2. Across-the-board restraint of rising medical costs nationwide without endangering quality of care or limiting access to service.

The Kennedy/Gephardt bill is designed to achieve effective and comprehensive cost containment in both the short term and

long term. It would do so through a balance of Federal and state regulations, public and private sector initiatives and innovation, and through financing and delivery reform. It also provides for a residual Federal program to assure that a minimum program is established nationwide while states implement their plans or in the event that some states fail to do so.

Now I will focus on some of the measures which are under discussion today as a means to contain health care costs.

Competition. That is a word we have heard a great deal since the Reagan Administration announced that "competition" is the way to solve the mounting problem of rising health care costs. It has been offered to us in many forms.

Some policy-makers tell us that competition is the shifting of costs to the consumer, old or young, rich or poor. The assumption is that the increased financial burden will force them to seek lower cost insurors and providers, who will in turn compete for business. Others tell us competition is the offering of a voucher to Medicare beneficiaries for the purchase of health insurance in the private market. The theory here is that the insurers will compete for the new Medicare business on the basis of price. Insurers tell us, however, that they cannot afford to sell Medicare's current benefits package for today's Medicare rates. Other competition plans include deregulation and the taxing of workers' health benefits which exceed a stated cap.

The list goes on, and includes many variations. All seem to increase the consumer's financial burden or encourage competition on the basis of price. What is missing from these "competition" schemes is competition among health care providers to offer the

best care in the most appropriate setting for the lowest cost. This kind of competition, we believe, is what we should strive for as a part of a comprehensive cost-containment plan or a step toward that objective.

Health care competition alone is not health care cost containment. It does not assure that providers will operate in a cost-effective manner, that they will assume financial risk for their actions, or that they will have incentives to save money.

The "competition" plans we have been offered to date are simply variations of payment for health care. They would neither produce effective, long-lasting cost containment nor assure quality and a comprehensive level of benefits. The closest we have come to reaching those objectives has been through the development of health maintenance organizations (HMOs).

HMOs work because they are based on alternative delivery and financing methods which compete with the conventional fee-for-service medicine. HMOs are both the insurer and provider. They are prepaid on a capitation basis. Since they assume financial risk, they have incentives to save money in the provision of service, to stress prevention of illness, and to use hospitalization judiciously.

HMOs have a long track record of containing costs effectively while providing their members access to comprehensive services when medically necessary. As such, HMOs have been encouraged by the Federal government and their reliability assured through Federal standards.

Today's hearing focuses on the discussion of health plans which are labeled "competitive." They could be preferred provider

organizations (PPOs), competitive medical plans (CMPs) or others based on the competition model. Proponents of these plans claim they are significantly similar to HMOs. NCSC urges Congressional members to exercise caution, however, before they jump on the PPO and CMP bandwagon. There are major differences, but, as I will point out later in my statement, they can be remedied through Federal law.

PPOs, CMPs, and other "competitive" variations are of very great import to senior citizens. The seniors' financial burden for receiving health care services is heavy, and it grows with medical inflation and each Federal budget year in which Congress opts for increasing beneficiary cost sharing instead of enacting cost containment. Senior citizens seek alternatives to the current expensive health care system, but their health and financial security is very vulnerable. They can neither afford to make mistakes nor can they afford to choose "competitive" alternatives which save money for the government but which hurt them.

Senior citizens also have a very large stake in the methods Congress enacts both to slow the rate of medical inflation and to assure Medicare solvency. PPOs and CMPs are being debated as possible means toward achieving those objectives. I will focus my comments on the merits of using plans such as PPOs and CMPs for these purposes.

The National Council of Senior Citizens does not oppose PPOs and CMPs in principle. However, we do not regard them as cost-containment measures. PPOs and CMPs are limited alternative means of paying for health services and we recommend that they be fully understood and approached with caution.

PPOs and CMPs are two of many steps that might be taken before comprehensive reform of delivery and financing can be enacted. If Congress is to encourage PPO and CMP development, we strongly urge the members to adopt strict consumer protections as well. For example, if state laws prohibiting PPO arrangements are overridden by Federal laws, consumers must in turn be protected by Federal requirements that assure minimum levels of services, quality, utilization review, and protection against skimming.

Let me elaborate on my points by using PPOs as an example. A preferred provider organization is really not a distinct entity as is, for example, an HMO. Rather, it is a contract or arrangement between a group of physicians, a hospital or hospitals, or possibly other providers and an employer, insurance carrier, or a third-party administrator acting on behalf of a group of health care purchasers. Generally, fee-for-service payment, although inherently inflationary, is preserved. The purpose of the PPO arrangement is negotiated discounts for the buyer and an expanded market for the provider. The buyer receives a discount for physician and/or hospital services if he/she agrees to use the "preferred providers." The "preferred providers" in turn receive a promise of increased volume, access to a selected patient population, and improved cash flow.

The PPO is not really a new concept, but it is one which has gained popularity in just the last few years. As health care costs rise, purchasers of health benefits -- in particular employers -- are looking for ways to cut their costs. PPO is a

response to the problem of rising medical costs and insurance premiums. Let me stress, however, that PPO is only a response and not the solution to the problem.

PPOs may have a short-term dampening effect on medical inflation because some prices are discounted. Their net effect on overall health care costs and total spending however is negligible. Two major factors account for this result:

- Only the group served by the PPO enjoys the discounted fee; non-PPO consumers may pay higher prices to compensate for the provider's income lost through the discount.

- PPO providers can increase the number of units of service provided to maintain a desired income since the price per unit is lower.

Unfortunately, many people have been fooled by PPO's only apparent effect on health care spending. To look at this artificially-produced effect as proof that we do not need regulation or system reform would be a big mistake. Discounting the price of health care is not, nor is it a substitute for, containing the cost of health care through provider efficiency and incentives. We believe that long-term, effective cost containment can only be achieved through comprehensive reform of payment and delivery of health services. Reform must provide for measures that encourage provider efficiency and include incentives for physicians, hospitals and other caregivers or suppliers to be financially accountable for their decisions. Reform must also produce cost savings nationwide, not just for selected groups.

We support the Kennedy/Gephardt cost containment and Medicare solvency legislation as a response to these needs. It encourages the development of HMOs and CMPs but does so within

the context of broader reform, recognizing that they are but a part of a larger scheme. Before comprehensive reform is enacted, we encourage the development of short-term cost-containment measures on both the private and public sides of the health issue. But incentives for efficiency must be a part of these measures if they are to be meaningful.

Many positive steps have already been taken by consumer groups, business, labor unions and others. In fact, much of their activity has occurred because Congress has failed to enact major legislation to solve the health care cost crisis.

Let me stress, however, that these are only small, intermediate steps. They do not address or solve the scope of our national problem. They do not help those citizens without access to health care. They do not significantly alter the nation's enormous health care bill. However, they can lead us toward the direction of Federal legislation.

As an example, let me describe senior citizens' efforts to deal with a very serious problem that Congress has failed to remedy. Three out of four senior citizens incur doctor bills annually. Medicare pays on average only 56 percent of these bills. Last year, because so many doctors did not accept Medicare assignment, senior citizens had to pay an extra $2.5 billion to their doctors! The physicians' refusal to accept assignment and the resultant high fees represent one of the most onerous problems senior citizens bear as a result of Congressional policy.

Congress has rejected several opportunities to remedy this situation. The latest forgone opportunity was the House of Representative's defeat of mandatory assignment as part of the "deficit

reducing" freeze on doctors' reimbursement levels and the Senate's refusal to make mandatory assignment a part of its deficit reduction package.

The Congress of the United States has been hoodwinked by the American Medical Association's archaic, irrational, distorted, and well-financed campaign against the elderly of America. Consequently, Senators and Representatives, elected to represent citizens, have failed to address the real problems in our health care system and the real problems of the aged.

Well, senior citizens are tired of having Medicare policy written in Chicago by the AMA. They are tired of waiting for this Congress to represent them and act on their behalf. They have taken matters into their own hands. On the local level, seniors are using their lists of physicians who accept assignment, and they are meeting with doctors and medical societies on a one-to-one basis. They are getting results.

What the AMA fails to realize is that doctors like Medicare! Too much of their income is derived from the Federal program they love to hate. They won't give it up -- no matter what the AMA tells the Congress. That's what seniors are discovering when they tell doctors they won't use their services unless the doctors accept assignment.

The AMA may act tough when it prowls the halls of Congress. It may act tough when it issues its edicts from Chicago denouncing Medicare prospective cost-containment policies as socialized medicine or when it claims that doctors can only sacrifice quality

or access if they are expected to contain costs. But the truth is, doctors do not act tough when they are threatened by the loss of a Medicare patient. The AMA knows that -- but it has fooled the Congress with its tough guy act.

Seniors are not fooled and that is why their assignment campaigns are working. Incidentally, their success shows the power of consumer information. Is it any wonder that the AMA vehemently and publicly opposes the Wyden amendment currently before the House of Representatives? The amendment would enable purchasers of health care to have access to information about fees and performance of doctors and hospitals so the consumers can make cost-effective health care decisions. Consumer information is a key ingredient to effective competition!

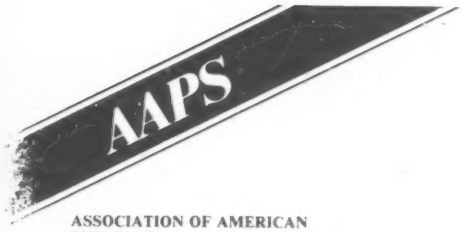
In spite of the success of assignment campaigns, they are able to reach only a limited number of senior citizens. The campaign successes are but a ripple in the ocean of problems caused by rising medical costs. To enable the elderly across the country to benefit from 100 percent assignment, senior citizens need firm Congressional action!

The same is true with across-the-board cost containment. We will never achieve it by relying solely on private efforts, by waiting for states to enact plans without a Federal push, or by depending on consumer advocacy. We need the commitment of the Congress. We need Federal incentives and guidance. Without these elements, there will be no consistent, rational control over spending, and the most vulnerable citizens will bear the greatest cost.

Senator QUAYLE. Thank you very much, Mr. Hutton.

I know Senator Kennedy was going to try to make it back, but unfortunately, he is not going to be able to. I know he wanted to welcome both of these witnesses.

[Additional material supplied for the record follows:]



ASSOCIATION OF AMERICAN
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WRITTEN TESTIMONY PRESENTED TO
THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
JUNE 21, 1984
BY THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

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The Association of American Physicians and Surgeons is a national, voluntary non-governmental organization of private medical practitioners. AAPS is dedicated to preserving free choice in the patient-doctor relationship, and protecting the practice of private medicine. We are pleased to have this opportunity to present our views on competition in the marketplace.

The crisis of the high cost of health care is a major concern to everyone today. Various proposals are being discussed, and legislation is being introduced to tackle the problem. Before solving the problem, we must first understand what has caused it. Our health care economic system has, unfortunately, evolved into one that is not a free market. Today it possesses few, if any, marketplace controls. It is fitting, then, that this Committee is holding hearings on competition in the marketplace, because that is exactly what is needed. We must take the steps necessary to restore medical economics to a truly cost-effective, free market system.

We must also understand how the patient's removal from the economic transaction has resulted in uncontrolled inflation and huge variations in health care costs. Because he does not pay directly for his services, or is reimbursed if he does, the cost matters little to the patient. He has little or no incentive to make price a factor in choosing his medical care. Again, the problem is that we do not have a free market in the medical care system. Our system is in market failure.

But the restoration of medicine to a sound financial footing will be difficult. It requires sacrifice on the part of both patients and providers. The political obstacles will be numerous.

In order to have a marketplace which performs in a proper, orderly manner, certain structural requirements must first be met. None of these exist in today's medical economic system. In general, there are five requirements which must be met for a sound market to exist:

* a fair and effective price mechanism felt by both providers and patients
* ease of entry into the system by both providers and patients
* non-collusive behavior among competitors
* adequate consumer information
* a tax structure which is supportive, and does not penalize

Probably the most important of these requirements is a fair and effective prive mechanism. This is almost totally absent from today's system because the patient is insulated from the true cost by his insurance. This is seen most dramatically in hospital charges because most insurance policies provide first-dollar coverage (this is insurance which does not require a co-payment by the patient, nor does it have a deductible) for hospital expenses. True economic competition will be present only when physicians and hospitals compete for the

patient's dollar. What we have today between doctors and hospitals is rivalry, not economic competition. They are competing on non-price factors, which is cost-generating competition.

Essentially we have a medical arms race, not a system that produces cost-effective medical care. For example, hospital administrators frequently compare themselves to the presidents of large corporations, but nothing could be further from the truth. The manager of a corporation thinks first about the cost of its product; if the price is not competitive, the company will fail. Hospital administrators do not have the same concern -- the system rewards them for managing an elaborate system which passes costs on to patients and industry (which buys insurance for its employees). The effective hospital administrator controls his board of directors, influencing them to consider their responsibility to the hospital, rather than the community. They are convinced that further hospital expansion is necessary to be more successful than the other hospitals; the local political structure is convinced of the necessity of the additions for the "community good"; then the political structure approves tax-exempt bonds to finance the expansion. No economic controls exist to impede this runaway explosion of costs.

Some businesses have become involved in attempting to reduce their health care expenditures, and are finding they can lower their costs by introducing market controls. Business health care coalitions are being formed in communities around the country, and they are succeeding. In Dayton, Ohio, for example, local doctors joined together with businesses -- NCR and the Mead Corporation in particular -- to help reduce their health care expenses. AAPS board member, Dr. John Boyles, Jr., was one of the physicians who encouraged the companies to involve the patients in the cost of their health care. Co-payments and deductibles in the insurance plans were introduced or increased, giving the patient an incentive to shop around for competitive prices. The results have been impressive: hospital usage in Dayton is down considerably; health care costs, normally increasing at 25% per year for NCR were <u>down 2%</u> in 1983, saving NCR <u>five million dollars.</u>

The second requirement of a sound marketplace, the ease of entry into the system, is at present being destroyed. The call for "alternative delivery systems" is increasing, but these restricted systems are limiting entry to the marketplace for patients and providers. Examples of these systems are preferred provider organizations (PPOs) and health maintenance organizations (HMOs). They should be resisted in the interest of fair competition. They take away the patient's freedom of choice, form a monopoly and set prices artificially.

These types of controlled economic plans encourage the violation of the third principle, that of non-collusive behavior among competitors. Closed panels of physicians, fee schedules, selective discounts and multi-value scales are all examples of collusive behavior in attempts to set up a monopoly; these are examples of what the HMOs and PPOs are doing. To lower costs, providers should be forced to compete with one another on quality, price and availability.

Of course adequate consumer information is vital to the patient making economic decisions regarding his health care. In many cases this information is already available, or would be at the patient's asking.

The last requirement of a sound marketplace is a supportive tax structure. Our current tax laws are flawed in several ways which increase the cost of medical care. Employee benefits are not taxable for the employee and deductible for the employer, encouraging the employer to increase benefits but not wages. With the increased insurance coverage, frequent, often unnecessary, use of medical care by the employee is encouraged. The system of tax-free bonds is another flaw. If hospitals are to function as efficient businesses, they should be financed like other businesses, not subsidized by the taxpayer.

The absence of marketplace controls in medical care delivery has not only allowed uncontrolled escalation of costs, but has created new obstacles to the restoration of cost-effective medical care. One of these is the problem of manpower. The education and creation of health care personnel, both physicians and paramedical personnel, should be controlled by a sound and competitive marketplace. Unfortunately, our medical education system is subsidized by federal and local governments, so students are shielded from the true cost of their education. They are not forced to look at the availability of jobs in the marketplace, and therefore are persuaded to enter careers in which job openings are inadequate. As the number of physicians has increased, it has been shown that in today's non-competitive system too many physicians produce too much medical care, driving up overall costs.

Another obstacle to cost effectiveness can be found in the actions of hospitals to expand into a primary care role. To stay in the forefront, the modern hospital must continue to build and beautify its facilities, as well as keep its beds full and increase its physician roster. Administrators are seeking to establish outpatient clinics, alcohol units, elaborate rehabilitation units and other marketing devices to produce income. It is not the fault of the administrators that their actions drive up health care costs, but the fault of a flawed economic system which rewards hospitals, as well as physicians, for inefficiency. Therefore we must seek to change the system, to make it cost effective.

Also, it is necessary to avoid the continual calls for more government regulation to solve the problem of high health care costs. The most recent is the Medicare Solvency and Health Care Financing Act introduced by Mr. Kennedy and Mr. Gephardt, which would institute direct federal or state control of hospital and doctor's bills.

The history of economics has shown that a regulated economic system ultimately produces a breakdown in quality and eventually, scarcity. We are the last Western society that does not have socialized medicine. If we do not restore competition in medicine, our health care system will surely evolve into a government bureaucracy which will be to the detriment of all -- patients and physicians alike. What are

the effects of regulated, taxpayer-funded socialized medicine? Waiting lists are long. The quality of care declines and medical care becomes impersonal, routine and bureaucratized. Care must be rationed -- dialysis and organ transplants are not common, and are unheard of for elderly patients. In France, the government has recommended that patients 70 and over be denied admission to intensive and critical care units, because they are no longer contributing to the state. Euthanasia has been proposed for all children under the age of three with significant congenital abnormalities because their care is too expensive. In Italy, the general practitioner must be available 12 hours a day, six days a week. Government permission is required to refer a patient to a specialist, and patients are only allowed three drugs, regardless of their need. In Zurich, a referendum was passed urging euthanasia for unproductive and expensive patients.

What is the answer? How can we restore a sound marketplace? How can quality care be delivered in the most cost-effective manner? There are several steps to be taken now.

* Establish s supportive tax structure. Repeal those tax laws which encourage overutilization of health care facilities.

* Oppose "alternative delivery systems" like HMOs and PPOs and other restrictive systems which create a monopoly, taking away a patient's right to choose his doctor and hospital.

* The government should end subsidies for hospitals, HMOs, medical education, etc. which contribute to the overproduction of facilities and manpower.

* Encourage a return to the true insurance principle: that of sharing the risk of catastrophes, rather than the coverage of every doctor visit and prescription.

* Hospitals should be returned to their original, basic role: that of caring for the acutely ill.

* The government should be removed from the medical care business. Professional standards review organizations and health planning laws, both of which have failed miserably, should be repealed. The newly enacted diagnostic related groups (DRGs) should be repealed -- this is a system which will encourage second class treatment for Medicare patients.

In the interim, while the marketplace is being restored, voluntary health planning should be encouraged. Community health care coalitions made up of representatives from industry, medicine, hospitals and insurance carriers can work together in an educational manner to help restore sound marketplace principles. As mentioned earlier, the success of the coalition in Dayton, Ohio in reducing health care costs has been dramatic. These coalitions should be privately funded by the members involved and should oversee the data collection which will provide marketplace information.

If we can return the patient to the status where he again has fiscal responsibility, true competition can prevail. The patient is the only fair and equitable controller of the price of medical care. A truly competitive marketplace always produces the best product at the least cost.

NATIONAL FARMERS UNION

STATEMENT OF

NATIONAL FARMERS UNION

TO

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

REGARDING

HEALTH CARE COST CONTAINMENT STRATEGIES

JUNE 21, 1984

National Farmers Union supports the principles outlined in the Medicare Solvency and Health Care Cost Containment legislation introduced by Senator Edward Kennedy as S. 2424 and Representative Richard Gephardt as H.R. 4870.

We support health care cost control legislation which would contain the costs of public and private programs while at the same time protecting consumers of health care and we believe this legislation would develop such a program. Each state would devise its own plan, as half a dozen states do now under individual state legislation. National legislation would assure basic minimum protections.

Annual negotiations among providers, payers, and consumers would replace rate-setting by any one party, and allow maximum participation of all affected parties.

We support prosspective budgeting for all payers and providers of health care services, with assured access to the health care system and protection of the quality of health care. Reimbursement by Diagnostic Related Groups (DRGs), a prospective fee schedule for payment to hospital by Medicare incorporated in the Social Security Amendments of 1983, is a partial approach to hospital cost containment which we hope will be adopted by private payers.

600 Maryland Avenue, S.W. • Suite 202 • Washington, D.C. 20024 • Phone (202) 554-1600

Mandatory assignment under Medicare for all physician payments (80 percent of usual and customary charges paid by Medicare and 20 percent by the patient) should also be extended to private payers in an effort to get some control of the 20 percent of health care costs represented by physician services.

The legislation encourages development of alternative health care plans such as Health Maintenance Organization which have demonstrated their effectiveness in delivering needed services and promoting preventive health care for their members.

Total national expenditures for personal health care in 1982 were $300 billion, representing 10.5 percent of the Gross National Product, the highest in history.

Even with such high outlays, it is estimated that more than 45 million people lack access to care or have inadequate health insurance coverage. They include the unemployed, many in rural areas, farm families who have lost their farms or have low farm incomes, and the near-poor who fall between the cracks in the present system.

It is estimated that for the period 1985 - 2005, this legislation would produce $2.4 trillion in private health care savings and achieve a net surplus of $29 billion in Medicare.

We urge prompt Congressional enactment of this legislation which would mount the effort to control skyrocketing costs of health care.

Building Blocks for Health Care Reform

BY DAN QUAYLE

An incremental approach can curb overspending, while preserving access to quality care.

HEALTH POLICY REPORT

What is one of the most talked about issues in corporate board rooms today? Health care costs. Traditionally, the cry to do something about rising costs in this area has come from proponents of increased government intervention. But the constituency for doing something about health care spending has grown.

Newly emerging and politically powerful groups are demanding that the issue be given more attention. Management and labor alike want reforms in health care delivery and financing.

The question remains, however, what shape will future reform of the health care system take? Should it be incremental, so as to provide incentives for the consumers, providers, and payers of health care to take positive steps to curb costs? Or should it be driven primarily by systemwide federal regulatory initiatives aimed at capping costs?

No "Magic Bullets"

The latter approach assumes there is a "magic bullet," a government policy which can limit health care expenditures without adversely affecting the quality of care or access to health services. The search for such a policy is not new. Past administrations, for example, have centered on bureaucratic efforts to promote health maintenance organizations, or cap hospital revenues as cure-alls to out-of-control health spending.

A third approach has included market-oriented strategies such as the Gephardt-Stockman proposal in 1980, which was designed to unleash market forces that would guide provision, purchase and consumption of health services through such cost containment tools as a tax cap on employer paid health insurance premiums. A comparable approach has been proposed by the Reagan Administration, but this competition model has never actually seen the light of day.

A recent proposal by Sen. Edward M. Kennedy (D.-Mass.) and Rep. Richard A. Gephardt (D.-Mo.) is the newest initiative to follow in this tradition of systematic approaches to reforming the health care delivery system. The Kennedy-Gephardt proposal attempts to accommodate both the concept of revenue caps and competition. Their legislation would create a federal all-payer prospective payment regulatory system, but would allow waivers for states adopting rate-setting or alternative delivery systems which could accomplish the same cost reduction goals. The authors assume the price setting arrangements mandated at the federal or state levels by the legislation would make providers more efficient and reduce unnecessary capacity.

These expectations probably are overly optimistic. At worst, the application of this all-payer program nationwide would cause inefficient allocation of resources within the health care system. It also might stifle innovation both in delivery and financing and possibly even lead to suboptimal care.

Taking a Positive Perspective

The alternative to "magic bullets" is to take an incremental approach to cost containment, which both recognizes the realities underlying the cost issue and provides incentives for reform of these realities.

To begin with, it should be recognized that about 60 percent of recent health cost increases is due to general economic inflation. However, it is the remaining 40 percent of these increases, due to other factors, that incremental reforms should focus upon. In tackling this second set of factors, there are two ways of looking at the current cost problem. From a negative perspective, health care cost inflation may be attributed to overly demanding consumers who are uninformed about the cost implications

Sen. Dan Quayle (R.-Ind.) is chairman of the Senate Labor and Human Resources Subcommittee on Employment and Productivity.

of health care or are simply excessively deferential to their physicians. Then there are the physicians who are interested in maximizing their incomes and are caught up in the technological imperative, regardless of its economic effects or, in a few cases, its impact on the quality of death for terminally ill patients. Hospitals that are underutilized, poorly managed, and prone to building new facilities or adding equipment for the wrong reasons also can be blamed. And third party payers contribute to the problem because they basically are insulated from market forces.

Viewed from another perspective, however, the realities underlying rising health care costs appear entirely different. The gradual aging of the U.S. population, the greater demand for services by the disadvantaged, the medically legitimate though expensive technological breakthroughs, and the overdue upgrading of many hospitals are all factors contributing to higher costs. These realities reflect the complexity of the health care system which any resolution or set of resolutions to the cost issue will confront. Initiatives adopted in this area must account for a myriad of economic, social, and political factors together with the idiosyncracies of health care providers who render services in a decentralized and pluralistic health care system.

"...Any approach to solving the cost problem will not succeed merely through legislative fiat. Solutions must be developed that meet the mission of cost containment without disruption of the current delivery system...."

Therefore, any approach to solving the cost problem will not succeed merely through legislative fiat. Solutions must be developed that meet the mission of cost containment without disruption of the current delivery system, and that avoid applying sanctions which will provide results unacceptable to major groups of consumers such as the elderly, health care providers, and payers.

A working example of an incremental approach to reform is Medicare's prospective payment system for hospital care. Initially, prospective payment will not reduce radically Medicare's bill for inpatient services, nor will it provide the savings necessary to assure solvency of the Medicare Hospital Insurance Trust Fund. However, by replacing cost based reimbursement with a system based on price per case, prospective payment alters incentives of providers and facilitates better management of hospital resources available to the Medicare population. Prospective payment should help reduce overutilization of services. It is a positive, incremental step.

Nevertheless, it is a reform strategy not easily applied to many providers. Because the system is based on averages, prospective payment will affect some institutions unfairly and, perhaps, harm some of the efficient as well as the inefficient facilities.

For example, there is a current storm of controversy over the arbitrary determination of hospitals as rural or urban. Congress certainly will modify the geographic designation of hospitals as well as make adjustments in other areas of the prospective payment system as needed.

The potential adverse effects of prospective payment demonstrate the need to proceed cautiously with health care reform to avoid unwanted results of a major policy decision. This same attitude of reform is central to an incremental strategy. Policies included under this approach need not be directly complementary but should not be contradictory.

Sound incremental reform should include policies designed to redirect behavior of consumers, providers and payers in the health care system. To be market oriented, initiatives should promote competition between providers on the delivery level, and third party payers on the financing level, while making consumers conscious of the economic implications of their health care decisions. At the same time, initiatives may be directed to reduce inefficiencies in the delivery or financing of care which the market, itself, through increased competition may fail to reduce.

Community pressures on providers, applied through business coalitions, can lead to better distribution of hospital resources and limit hospital expansion that is not cost-effective.

Areas Ripe for Reform

With these themes at the base, the following are areas in which initiatives could be taken at the margin to reduce cost. The agenda provided here is by no means exhaustive and presents only a beginning to which a range of other incremental proposals may be added.

Alternative Delivery Systems. At the root of the high cost of health care is the current oversupply of hospital beds and certain other services. In a noncompetitive health care environment where some form of insurance covers most inpatient services, there is an inherent incentive to overuse hospitals.

To counter this tendency, financing and delivery mechanisms may be developed that discourage over-utilization. HMOs and the newly designed competitive medical plans (CMPs) succeed in lowering hospital utilization rates and, subsequently, health care costs. In Massachusetts, for example, HMOs have even reduced hospitalization and costs for Medicare enrollees.

Federal legislation requires employers to offer an HMO option in their health plans when it is available. This legislation is extremely prescriptive. It should be amended to provide the same recognition to CMPs, which are similar in structure and purpose to HMOs but less constrained by regulation. Placing CMPs on the same footing as federally qualified HMOs would encourage their development.

Another health care delivery and financing model which seeks similar ends is the preferred provider

arrangement or organization (PPA). Under the PPA model, insurers, employers or third party administrators contract directly with physicians and/or hospitals who agree to provide health services in a cost-conscious manner under strict utilization controls. In exchange, the payers promise prompt payment and financial incentives for their beneficiaries to patronize the preferred providers.

The development of PPAs can be fostered by legislation. Barriers in the form of state insurance laws and regulations which restrict PPA formation by insurers should be removed. Many state legislatures are moving in this direction, but momentum would be enhanced by federal legislation. The federal government should allow Medicare to contract with PPAs, as both the program and individual beneficiaries would benefit from this approach. A similar opportunity exists now for Medicare to contract with HMOs and CMPs. PPAs might be allowed access to the Medicare market — starting with outpatient care — to test their usefulness.

Consumer Information. The increased availability of consumer information in the health care marketplace is another area worthy of further development. Part of the reason that there has been insufficient competition in the health care arena has been the lack of price and quality of care information. For health care to become more competitive, consumers will have to be given access to easily understood and relevant cost and quality data.

Major strides have been made in the collection and distribution of price information in various parts of the country. In Minneapolis, the Council of Community Hospitals has published a document including the prices for most of the services provided by area hospitals. This weighty data base provides eye-opening background information to payers and providers, and is being used by hospitals to point out cost variations among institutions to consumers.

Similar information has been collected and distributed to the public by the Utah Health Cost Management Foundation, a nonprofit group including business, providers and consumers. An agency of the Iowa state government also collects and will disseminate hospital price information to the public.

These data collection activities should be encouraged, and their impact on the health care market and consumers should be studied by the U.S. Department of Health and Human Services. These programs may offer models worth replicating in other areas of the nation. The concept might even be expanded to include the costs of outpatient and ambulatory services.

In addition to cost data, information on the quality of care would also be useful. The development of quality indices, however, has been a much knottier problem and, currently, there is no generally accepted system for making such determinations. Some studies have shown the most effective provider institutions are those which specialize in performing certain procedures and treatment. With bypass surgery, for example, the medical centers that perform the highest volume of this procedure have the lowest mortality and morbidity rates and, frequently, the lowest cost.

Quality information is sensitive and can be misinterpreted if not presented appropriately. For instance, a utilization review committee at one major corporation, in examining physician practice patterns in a given area, found that one cardiologist had an 80 percent patient mortality rate. On the surface, this statistic reflected badly on that physician. But further examination revealed that he was a highly specialized practitioner who treated only the sickest patients. His 20 percent survival rate actually was excellent considering his patient population, but this conclusion might be obscured in an arbitrary assessment of quality data.

Despite such pitfalls, there must be formats through which the public can be provided a set of indices to judge the variations in quality of care among providers. HHS should examine the use of quality measures which have been developed and encourage the development of additional models.

Public disclosure of such information must, however, be provided with great care and through an appropriate mechanism. Government should not develop a health care consumer protection-like agency to compile and distribute data on medical and hospital services. This would only add a new layer of bureaucracy and be counterproductive, whereas activity at the state and local level would better reflect community standards.

Disease Prevention. Health promotion and disease prevention provides another area where concerted effort could lead to lower health care costs as well as an increased quality of life. By implementing educational programs that encourage individuals to alter their life styles, thereby lessening their disease risks, much can be accomplished.

A step forward in this area would be to require employers who offer health insurance to provide their employees with access to a blood pressure screening program. Statistics on the cost to employers of untreated high blood pressure among employees are staggering. About 26 million work days representing $1.3 billion dollars in earnings are lost each year because of cardiovascular diseases. One company, New York Telephone, estimates it saves at least $85,000 a year as a result of a high blood pressure control program for its 5,000 hypertensive employees.

It is worth noting that national high blood pressure control statistics have been reversed by worksite programs. Eighty percent of participants in these programs have brought their blood pressure under control. In comparable community based programs, only 20 percent of hypertensives come under control after detection. Clearly, the worksite is the best location to pursue a simple program with the potential for dramatic effects.

Health Care Technology Assessment. Reform based on provider and consumer incentives to change use of health resources may not provoke the efficiency necessary in the application of new and existing health care technologies.

The last few decades have seen a proliferation of new health care technologies which may be broadly defined to include increasingly sophisticated drugs, and medical and surgical procedures requiring expensive equipment. In many cases, new technology has led to increased costs without apparent benefits. For example, some experts argue the widespread use of fetal monitoring techniques has led to a greater number of caesarian sections without clear advantages. Thus, there is a need for better assessment of new technology.

The health care system currently is unable to coherently evaluate, in medical and economic terms, new or emerging technologies, as well as those already in widespread use -- and the situation is likely to worsen. As a further complication, certain otherwise obsolete technologies may remain in use because of disincentives under prospective payment and other case based payment systems to alter accepted patterns of treatment.

"For health care to become more competitive, consumers will have to be given access to easily understood and relevant cost and quality data."

In a recently released report, ***The Painful Prescription: Rationing Hospital Care***, Henry J. Aaron of the Brookings Institution and William B. Schwartz of Tufts University note that the U.S. is entering a period of constrained resources in which the tendency may be to limit applications of new technologies rather than set priorities for technologies that should be adopted or continued. Neither the market nor the federal bureaucracy is the appropriate entity to make such decisions.

Instead, capacity must be developed in the private sector to carry out health care technology assessment. An entity is required which will promote, through recommendations, the emergence and application of appropriate new health care technologies and the elimination of inappropriate and obsolete ones. This entity must have the authoritative status to make it acceptable to providers and consumers, and must be primarily supported by the private sector which should set its agenda. Providers and payers should join together to form this entity along with the federal government. The proper role of the government should be as a facilitator, and perhaps even the catalyst. Legislation to pave the way for development of this venture is needed. It may take a number of years for such an entity to define its role and develop widely accepted tools of assessment, but this process needs to get started.

Health Planning. Mechanisms are also necessary to keep capital expenditures in line. Neither the financial bond markets nor the array of disincentives to overbedding offered by prospective payment will be sufficient to curtail unnecessary capital investment by institutional providers. Communities should be assured a role in decision making concerning major capital investments proposed for the health care marketplace, since it is the communities -- and employers in particular -- that ultimately foot the bill.

One approach, put forth in Quayle-sponsored legislation introduced last August, is to change the current health planning system into a block grant program that would give states and local constituencies the freedom to choose the best method for allocating health resources. However, the most appropriate role for government, business, community leaders and the general public in these types of decisions is still evolving.

Medical Malpractice. The cost of medical malpractice, both direct and indirect, also has contributed significantly to the overall inflation of health care costs in recent years. Medical malpractice offers an area ripe for congressional examination. This is illustrated dramatically by a survey by the American College of Obstetricians and Gynecologists which indicates that in recent years fees have increased as much as 30 percent to meet the growing cost of medical liability insurance. It can be assumed that other specialties and provider institutions also have experienced significant increases due to growing insurance premiums.

In addition, fear of suits has led increasingly to the practice of defensive medicine. The same survey of obstetricians found that the threat of litigation caused these physicians to order more tests and other diagnostic procedures than they otherwise would have ordered. They also prescribed longer hospital stays. Reversal of this incentive would not affect the quality of medicine but would reduce utilization.

The malpractice problem frequently pits physicians against hospitals, and the health care system against patients. This adds to the cost of litigation and adversely affects relations among providers. Whatever reform is developed should limit the adversary relationships which occur due to malpractice litigation.

Historically, malpractice has been under the purview of state tort law and the federal government has been reluctant to intervene. Tort law concerning malpractice was substantively amended in the mid-1970s to meet the crisis stemming from increasing malpractice awards which were driving up health care costs. But it is not apparent that these reforms have contributed to a slowing of the increase in awards, premiums for liability insurance, or the perceived threat providers face from malpractice. Many no-fault insurance alternatives have been suggested as solutions to the present situation. But this approach poses problems with defining injury, determining entitlement to compensation, and deciding on the type of compensation to award. The concern over costs associated with malpractice liability is heating up and deserves review.

The incremental approach to reform suggested above will allow Americans to meet their cost containment goals without undermining their high quality health care system. The specific initiatives proposed are suggestive of options which might be undertaken at this time. ■

Senator QUAYLE. I am about 20 minutes late for my next appointment. We started a little bit late this morning because we were in until 4:30 last night. So, I am going to thank both these witnesses. Your entire statements will be put in the record, and the committee will stand in adjournment.

[Whereupon, at 1:53 p.m., the committee recessed, to reconvene subject to the call of the Chair.]

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